STUDENT SEIZURE HISTORY

STUDENT Student Name and DOB	
SEIZURE DIAGNOSIS Tell me what type of seizure disorder your child has been diagnosed with?	
TYPE OF SEIZURES Tell me about what your child experiences with a seizure?	
SEIZURE ACTIVITY When was your child's last seizure?	
FREQUENCY How often does your child experience seizures?	
DURATION How long do the seizures typically last?	
TRIGGERS Is there anything that triggers seizure activity for your child?	
REGULAR MEDICATION Does your child take medication daily for seizures?	
EMERGENCY MEDICATION Does your child have emergency medication for seizures?	
VNS Does your child have a VNS?	
DIET Does your child follow a ketogenic diet?	
RESTRICTIONS Does your child have any restrictions related to seizures?	
ACCOMODATIONS Does your child require any accommodations related to seizures?	
NEUROLOGY? Who is your child's Neurologist? When was their last appointment?	
FORM COMPLETION Who completed this form? Date?	