Chandler Unified School District #80

Seizure Disorder History

Student Name:_____DOB:_____

School:_____Grade:_____Date:_____

1. What type of seizures does your child have? Please describe your child's typical seizure.

_____

2. How often do seizures occur? How long do the seizures normally last?

_____

3. When was your child's last seizure?

_____

4. Has your child ever stopped breathing during a seizure? ☐ No ☐ Yes If yes, how is that handled?

_____

5. Is there anything that seems to trigger a seizure? ☐ No ☐ Yes If yes, please explain.

_____

6. Does your child experience an aura before a seizure? ☐ No ☐ Yes If yes, please explain.

_____

7. Does your child require the use of any protective equipment (i.e. helmet)? ☐ No ☐ Yes If yes, please explain.

_____

8. How are your child's seizures treated?

_____

9. Is your child currently taking medication to control their seizures? ☐ No ☐ Yes If yes, list name, dosage, and how often your child takes this medication. **If the medication is to be kept in the health office, a Consent for Medication Administration form must be on file.**

_____

Parent/Guardian Name (Print):_____Phone No. _____

Parent/ Guardian Signature: _____Date: _____