Edmonds SCHOOL DISTRICT
Each student learning, every day!

STUDENT HEALTH SERVICES
Seizure Disorder Form

Student: ___________________________ **Date**: ________ **DOB:** __________ **Grade:** _______

SEIZURE INFORMATION:
Type of seizure ____
Description of seizure: ____
____
Length of seizure:____
Average time before return to regular activities: _______________________________________
Ever stop breathing?: ____
Possible warning and/or behavior changes prior to seizure: _______________________________
____
____
Frequency of seizures: _______________ ☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly
Usual time of day seizures occur:____________________ Date of last seizure: _______________
Student's reaction to seizure: ____
When did seizures begin?:________________________When diagnosed? ___________________
Any change in seizure pattern?: ☐ No ☐ Yes, please describe: _____________________________
____
Do other illnesses affect your child's seizure control: ☐ No ☐ Yes, please describe: __________
____

MEDICATIONS:
Student currently on medication?☐ No:if discontinued when?: __________ ☐Yes: complete below

MEDICATION	Time/day	Dosage	Side Effects

Physician: ____ Phone: _____________________
How often is student seen? ________________________ When seen last? ___________________
Results of last visit/EEG: ____

SPECIAL CONSIDERATIONS
☐ Educational concerns: ____
☐ Behavioral concerns: ____
☐ Emotional concerns: ____
☐ Physical Education precautions: ____
☐ Recess precautions: ____
☐ Field trip considerations: ____
☐ Special transportation needs: ____
☐ Other: ____
☐ Play on after school sports teams/ participate in activities after school here at school?
____

___________________________ ____________________ __________________ ______________
Parent Signature/Date work phone/work hours home phone e-mail address

____________________________________ ____________________ ____________________
Emergency Contact relationship phone