GRACE LEARNING CENTER

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: _____