West Valley School District

Seizure Information for School

Student Name _____ Date of birth _____ Grade _____

Parent/Guardian _____ Phone _____ Cell/Work _____

Physician treating seizures _____ Phone _____

1. When was your child diagnosed with seizures? _____
2. What type of seizures does your child have? _____
3. Do you know what caused the seizures to start? ☐No ☐Yes: _____
4. Has there been a change in the seizure pattern? ☐No ☐Yes: _____
5. How often does your child have seizures? _____ When was the last one? _____
6. Do you know of anything that triggers a seizure? ☐No ☐Yes: _____
7. Does your child have a warning sign of a seizure? ☐No ☐Yes: _____
8. Describe your child's seizures: _____

   _____

   _____
9. What should school staff do if your child has a seizure? _____

   _____
10. Does your child have any restrictions because of the seizures or medications?

    ☐No ☐Yes: _____
11. Please list **ALL** the medications your child takes:

Name of medication:	Amount/dose:	When taken:

12. Does your child have any allergies? ☐ No ☐ Yes: _____
13. Other information or concerns? _____

_____ _____

Parent/Guardian Signature Date