SEIZURE DISORDER CHECKLIST

1. Name of student ______________________ Grade _____ Teacher ______________

2. Physician treating the seizure disorder: _____________________________________
   Phone : ____________________

3. What type of seizures does your child have?
   ____

4. Age at the time of diagnosis ____

5. What medications are taken to control seizure activity?
   Name ___________________________ Dose ______________Time(s) ___________
   Name ___________________________ Dose ______________ Time(s) __________
   Name ___________________________ Dose ______________ Time(s) __________

6. What is the date of the last seizure
   ____

7. How often do seizures occur? ____

8. Does your child know when he/she is about to have a seizure? Yes ___ No ___

9. What, if any, are signs that a seizure is about to occur?
   ____

10. What happens during a seizure? ____

11. What happens immediately following a seizure? ______________________________

12. What treatment should your child receive in school? __________________________

13. What, if any, are restrictions on activity? ____________________________________

14. Other comments:

Signature ____ Date _____________________