SEIZURE INFORMATION SHEET

Student's Name _____ Date Completed _____

This student is being treated for a seizure disorder. The information below should assist you if a seizure occurs during class.

Seizure type _____

Description of the seizure _____

_____

Possible triggers _____

Average length of time it lasts _____

Average length of time until student can return to regular activities _____

Possible warning and/or behavior changes prior to the seizure _____

_____

Average frequency _____

Usual time of day seizure occurs _____

Student's reaction to the seizure _____

_____

First aid you should provide _____

_____

The student is receiving the following treatment to control the seizure(s):

Name of medication _____ Name of medication _____

_____ _____

Amount and time given _____ Amount and time given _____

_____ _____

Possible side effects _____ Possible side effects _____

_____ _____

Other areas needing your attention _____

_____

_____

I have attached some additional information regarding this student's seizure type and treatment. If you have any questions, please do not hesitate to ask me. I am available from _____ to _____ on the following days _____

Otherwise, you can reach me at _____

School Nurse: _____