Date: _____ Childs Name: _____

Seizures

What type of seizure diagnosis does your child have? (febrile, absence, petit mal, grand mal, epilepsy, etc.)

_____

_____

How often do they occur?

_____

How long do they last?

_____

Does your child have an aura or warning sign of a seizure coming on? ☐ Yes ☐ No

If yes, please describe the aura or warning sign.

_____

Is your child able to alert someone of an on-coming seizure? ☐ Yes ☐ No

Describe child's symptoms during and after the seizure episode

_____

_____

Medication(s) prescribed for seizures, or seizure prevention (please list). How often and how much?

_____

_____

If your child has a history of febrile seizures, has he/she been to see, or referred to a neurologist?

☐ Yes ☐ No

Does your child have any activity restrictions? ☐ Yes ☐ No

Please describe restrictions:

_____

_____

** Any activity restrictions, medication parameters or special instructions related to the care of your child must have an accompanying note from the child's medical provider

_____ _____

Parent Signature Date Reviewed by Nurse Date

REV 10/2017