

# Seizure History

(Parent/Guardian to complete and return to Nurse)

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ School: \_\_\_\_\_

What type of seizure/s has your child been diagnosed with?

_____ Absence (petit mal)	_____ Partial (simple or complex)
_____ Atonic (drop attacks)	_____ Status epilepticus
_____ Febrile	_____ Tonic-clonic (grand mal)
_____ Infantile Spasms	_____ Other
_____ Myoclonic	

When was this diagnosis first made \_\_\_\_\_

What does your child's seizure typically look like \_\_\_\_\_

Does your child have any behaviors or sensations (such as an aura) that happens before a seizure?

If so, please describe: \_\_\_\_\_

Length of typical seizure \_\_\_\_\_

How often is your child having seizures? \_\_\_\_\_

Who is following your child's seizures? \_\_\_\_\_

Name of pediatrician \_\_\_\_\_ Last seen (date) \_\_\_\_\_

Name of neurologist \_\_\_\_\_ Last seen (date) \_\_\_\_\_

Have you ever had to call 911 or take your child to the Emergency Room for a seizure that was not to stop? Yes/No \_\_\_\_\_ How long was this seizure? \_\_\_\_\_

Please list any medication/s your child is taking to control seizure activity.

Medication Name