Southwest Christian School

# Seizure Questionnaire and Action Plan

Date:_____

Student:_____ Date of Birth:_____

Grade:_____ Teacher:_____

Physician:_____ Phone Number:_____

Significant Medical History:_____

Seizure Information-to be filled out by parent:

1. When was your child diagnosed with seizure or epilepsy:_____
2. Seizure type (s)

| Seizure Type | Length | Frequency | Description |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

3. What might trigger a seizure?_____
4. Are there any warnings and / or behavior changes before the seizure occurs? Yes No
   If YES, please explain:_____
5. When was your child's last seizure?_____
6. Has there been any change in your child's seizure patterns? Yes No
   If YES, please explain:_____
7. How does your child react after a seizure is over?_____
8. What medication's does your child take?

| Medication | Date Started | Dosage | Frequency | Possible Side Effects |
|---|---|---|---|---|
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |

Action plan for when/ if a seizure occurs:

_____
_____
_____
_____
_____
_____
_____
_____
_____