



Seizure/Epilepsy Information Sheet

Student's Name: _____ Grade: _____ Date: _____

Physician treating child's seizures/epilepsy: _____ Phone: _____

Approximately how often does your child have a seizure? _____

When was the last seizure? _____

Symptoms

Can any of the following trigger a seizure in your child:

- | | |
|---|---|
| <input type="checkbox"/> Lack of sleep | <input type="checkbox"/> Stress |
| <input type="checkbox"/> Flashing/flickering lights | <input type="checkbox"/> Missed doses of medicine |
| <input type="checkbox"/> Hormones | <input type="checkbox"/> Exercise |
| <input type="checkbox"/> Food/fasting | <input type="checkbox"/> Illness |
| <input type="checkbox"/> Caffeine | <input type="checkbox"/> Other _____ |

Types of seizures your child has had:

- | | |
|--|---|
| <input type="checkbox"/> Simple partial | <input type="checkbox"/> Complex partial |
| <input type="checkbox"/> Absence (petit-mal) | <input type="checkbox"/> Tonic-clonic (grand mal) |
| <input type="checkbox"/> Other _____ | |

Does your child have any of the following warning signs that a seizure is approaching:

- | | |
|---|---|
| <input type="checkbox"/> Sweating profusely | <input type="checkbox"/> Dilated eyes |
| <input type="checkbox"/> Aura | <input type="checkbox"/> Strange taste or smell |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Visual/Auditory disturbances |
| <input type="checkbox"/> Other _____ | |

Treatment

Does your child take medication to control seizures? Yes No

If yes, does your child have side effects from these medications? Yes No

Please explain. _____

Does your child understand his/her condition? Yes No

Comments: _____

Signature of parent/guardian: _____ Date: _____