Seizure Information Form

Please complete this form if the participant experiences seizures and return a signed copy of the participant's seizure plan from his/her doctor if applicable. Please update this form whenever there is any change with the seizure plan, medications, seizure activity or with any of the information that is provided below.

June 1 2019, - May 31, 2020

General Information

Date: /____/____ Name:_____Date of Birth: _____

Parent/Guardian Name: _____ Home #: _____ Cell #: _____

Emergency Contact Name: _____ Home #: _____ Cell #: _____

Seizure Information

Has the participant ever had a seizure? □ No ■ Yes

Does the participant have a Seizure Plan? This is often created by a medication professional or school nurse? □ No □ Yes

What type of seizure does the participant have? (Check all that apply)

□ Complex Partial Seizure □ Drop Seizure □ Grand Mal / Generalized Tonic-Clonic □ Myoclonic Seizure □ Petit Mal/Absence Seizure
□ Simple Partial Seizure □ Unknown □ Other_____

Description of seizure:

_____

_____

Are there any symptoms, triggers and/or auras prior to the onset of the seizure? (e.g. smells, stomach pain, fear, sounds) □ No □ Yes
If yes, please describe:

_____

_____

What was the month and year of the participant's last seizure?_____/_____

How long was the participant's longest seizure?

□ Less than 1:00 minute □ 1:00 - 1:59 minuets □ 2:00 - 2:59 minutes □ 3:00 - 5:00 minutes
□ 5:00 - 10:00 minutes □ 10:00 - 30:00 minutes □ More than 30:00 minutes □ N/A

Does the participant have a Vagal Nerve Stimulator (VNS)? □ No □ Yes

If yes, describe instructions for appropriate magnet use and where the magnet is kept during the program:

_____

_____

List any emergency medication to be used during and/or following a seizure (include medication name, dosage frequency and possible side effects). **NOTE: FVSRA will call 911 at onset of percieved seizure for anyone who utilizes emergency medication for seizures. FVSRA cannot administer rectal or injectable medication and cannot administer any emergency nasal or oral medication during the seizure (e.g. Diastat, Nasal Versed, Lorazepam). Upon request, FVSRA will hold and pass these medications to EMS/hospital staff in the case of an emergency.**

_____

_____

Describe participant's typical post seizure condition (lethargic, confused, etc.): _____

List any additional seizure information: _____

Seizure Response Plan

FVSRA policy is to call 911 after **3 minutes** of continuous seizure activity (or sooner if staff determines necessary). Would you prefer Emergency Medical Services (EMS) called at the initial onset of the seizure? □ No □ Yes

List any additional steps you would like taken in the event of an emergency _____

Name of Person Completing this Form: _____

Relationship to Participant:_____Signature:_____Date: _____