Nor-West Medical Addendum: Seizures

Participant's Name: ____

Neurologist's Name (print) & Phone:

____

Seizure Type: ____

Number of seizures per: Week_____ Month_____ Annually_____

Date of last seizure: ____

Typical Duration:____

Check off any stimulus listed below that tends to provoke seizures:

___ High outdoor temperature ___ High humidity ___Blood sugar

___ Bright light ___Flashing light ___Physical activity

___Other:____

Describe seizure aura, if any:____

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Describe symptoms:____

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____

Seizure medications:____

Please check off how you would like us to respond to a seizure when your son/daughter is at our program/"

___ Call 911 immediately & then call parent(s)

___ Call only parents to alert & for instructions

___ No calls; respond to seizure and document type/duration

Comments:____

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____ _______________

Parent/guardian signature Date