

NORWALK PUBLIC SCHOOLS
SCHOOL HEALTH SERVICES

Seizure Information Sheet

Student Name: _____ Date of Birth: _____
Parent/Guardian Name: _____ Phone: _____ Cell: _____
Treating Physician: _____ Phone: _____
Diagnosis: _____

1. What type of seizure does your child have, how often do they occur, and how long do they last?
2. Describe your child's symptoms during and after the seizure episode.
3. Does your child have an aura or warning of a seizure coming? Is she/he able to notify anyone that a seizure is coming?
4. List medications, dose, and time taken:

At home -

At school -

5. Does your child suffer any side effects to this medication? Please list.
6. Are there any activities in which your child cannot fully participate?

**PLEASE READ THE EMERGENCY HEALTH CARE PLAN FOR SEIZURES ON THE REVERSE SIDE,
AND ADD ANY FURTHER INSTRUCTIONS THAT YOU WISH FOR YOUR CHILD.**