SACRAMENTO CITY UNIFIED SCHOOL DISTRICT
Child Development Department

Seizure History

(Parent/Guardian to complete and return to Nurse)

Student Name: _____ Date of Birth: _____

Parent/Guardian: _____ School: _____

What type of seizure/s has your child been diagnosed with?

_____ Absence (petit mal)
_____ Atonic (drop attacks)
_____ Febrile
_____ Infantile Spasms
_____ Myoclonic
_____ Partial (simple or complex)
_____ Status epilepticus
_____ Tonic-clonic (grand mal)
_____ Other

When was this diagnosis first made? _____

What does your child's seizure typically look like _____

_____

Does your child have any behaviors or sensations (such as an aura) that happens before a seizure?

If so, please describe: _____

Length of typical seizure _____

How often is your child having seizures? _____

Who is following your child's seizures? _____

Name of pediatrician _____ Last seen (date) _____

Name of neurologist _____ Last seen (date) _____

Have you ever had to call 911 or take your child to the Emergency Room for a seizure that was difficult to stop? Yes/No How long was this seizure? _____

Please list any medication/s your child is taking to control seizure activity.

Medication Name	Route	Dosage	Frequency

When was the last medication or dose change? _____

Does your child need a protective helmet? (Circle one) At Play/At All Times/Not At All

Are there any special precautions the instructional staff needs to be aware of?

_____

_____

_____ _____ _____ _____

Parent Signature Date/Phone Nurse Signature Date