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 seizu

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

to stop? Yes/No How long was this seizure ______________________________

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

Medication Name