Education that inspires...Opportunities for all

GURNEE SCHOOL DISTRICT 56

3706 Florida Avenue • Gurnee, IL 60031 • 847-336-0800 • www.d56.org

Annual Seizure Activity Assessment Form

Gathering this information will assist in development and update of your child's health care plan.

Student Name: _____ Date of Birth: _____
Grade: _____ Teacher: _____ School Year: _____
Treating Physician's Name: _____ Phone: _____
Medical Diagnosis: _____
When was your child diagnosed with seizures? _____
Date of last evaluation: _____
Date of last seizure activity: _____
What medications does your child take? _____
Routine medications needed during school hours: _____
Emergency medication at school? □ No □ Yes, please list _____
_____
Allergies: _____
Does your child use a Vagal Nerve Stimulator? □ No □ Yes
What type of seizure(s) does your child have? _____
_____
What triggers a seizure for your child? _____
Describe what your child's seizures look like: _____
_____
How does your child act after a seizure? _____
_____
How might your child's seizure activity affect school performance or participation in activities?
_____
Has your doctor approved such activities as swings, monkey bars, climbing walls?
□ No □ Yes, please explain: _____
If your child has a seizure at school do you want the rescue squad called? (Please check):

☐ For any/all seizure activity ☐ Only if seizure lasts longer then 2-3 minutes

☐ If unresponsive to emergency medication ☐ Per my doctor's request

The rescue squad will be called for any seizure last longer then 5 minutes or non-convulsive seizure lasting more then 15 minutes.

Is there anything further we should know about your child's seizure activity?
_____
Parent/Guardian Signature: _____Date: _____

Distinguished Program