SRSNLC Seizure Questionnaire

Date: ____/____/____

Participant's name: _____

Parent/Guardian: _____ Phone _____/ _____/_____

Emergency Contact: _____ Phone _____/ _____/_____

Current Medication: (including dosage)

Name	Dosage	Time of intake
_____	_____	_____
_____	_____	_____

Seizure type:

- Absence (staring spell)
- Simple Partial
- Complex Partial
- Atonic (drop)
- Generalized (grand-mal)
- Other (Explain): _____

When was the date of your/your child's last seizure? ____/____/____
How long does the seizure last? _____
How long was the longest seizure? _____

Are there any triggers that cause the onset of your/your child's seizure? (I.e. strobe lights, heat, sudden movements, noise)

Explain: _____
_____
_____

Are there any symptoms prior to the onset of your/your child's seizure? (I.e. smells, stomach pain, fear, sounds)

Explain: _____
_____
_____

Seizure Plan

Please list below the necessary steps you would like SRSNLC to take in the event of a seizure:

1. Call 911 for a seizure over _____minutes.
2. _____
3. _____