Form 316-04

Cowichan Valley School District

School ________________
Teacher ________________
Grade ________________

SEIZURE FOLLOW-UP

Student's Name: ____________________________ Birth Date: ________________

Parent 1 Name: ____________________________ Relationship: ________________

Cell # ______________ Work # ______________ Home # ______________

Parent 2 Name: ____________________________ Relationship: ________________

Cell # ______________ Work # ______________ Home # ______________

Emergency Contact 1: ________________________ Relationship: ________________

Cell # ______________ Work # ______________ Home # ______________

Emergency Contact 2: ________________________ Relationship: ________________

Cell # ______________ Work # ______________ Home # ______________

Doctor's Name: ____________________________ Phone # ______________

Does your child have any warning symptoms before a seizure? (please describe)

What happens during a seizure?

What care do you want your child to have following a seizure?

When was the last seizure?

How often do they have seizures:

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Medications

Is your child on medication? ______________ If yes, please complete the information below

	Names	Times
(1)		
(2)		
(3)		

Describe possible side effects to the medication(s)

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IF YOUR CHILD WILL NEED MEDICATION WHILE AT SCHOOL, PLEASE ASK FOR THE APPROPRIATE FORM.

Do you have any additional health concerns for your child while he/she is at school?

____

Does your child wear a Medic Alert bracelet? ______________________________

______________________________ ______________________________

(Parent/Legal Guardian Signature) (Date)

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