ELLWOOD CITY AREA SCHOOL DISTRICT

501 CRESCENT AVE. ELLWOOD CITY, PA 16117
PHONE: (724)752-1591 FAX: (724)758-0534

SEIZURE INFORMATION FORM

Student:	**Grade/Class:**
Seizure Type:	
Seizure Description:	
Average Seizure Length:	
Seizure Frequency:	
Date of last Seizure:	
Behavior Following a Seizure:	
What will Trigger a Seizure:	
List any Warning Signs Before a Seizure:	
Please list any medications your child receives: (include name, dose, time)	
Do you have an EMERGENCY MEDICATION for extended seizures?(name, dose)	
IF YOUR CHILD NEEDS MEDICATION FOR SEIZURES, YOU WILL NEED TO SUPPLY THE MEDICATION AND NECESSARY FORMS WHICH CAN BE OBTAINED FROM THE SCHOOL HEALTH OFFICE.	
Parent Signature:	**Date:**

PLEASE FEEL FREE TO USE THE BACK OF THIS FORM TO SUPPLY ANY OTHER ADDITIONAL INFORMATION THAT YOU FEEL WOULD HELP US TO MANAGE YOUR CHILD'S SEIZURES AT SCHOOL. THANK YOU

ADDITIONAL SEIZURE INFORMATION FOR:

Parent Signature: **Date:**