

Seizure Disorder Assessment Tool

NAME:		SCHOOL:	
STUDENT NUMBER:		GRADE:	
DATE OF BIRTH:		DATE:	

History:

- When was your child diagnosed with seizures or epilepsy?
- When was your child's last seizure?
- Has your child ever had a seizure at school?
- What type(s) of seizure does your child have (ie: focal- aware/ impaired awareness, motor and non motor, generalized- impaired awareness, motor and non motor, unknown onset- motor and non motor)
- Has your child ever been hospitalized related to seizures?
- Does your child regularly see their doctor for seizure care and/or medication adjustments?

Symptoms:

- What might trigger a seizure in your child?
- Do the seizures start abruptly or gradually?
- Describe what your child's seizure looks like
- How long do your child's seizures usually last?

Treatment:

- How long does it take for your child to return to normal activity after a seizure?
- Under what circumstances should a parent be called if there is seizure activity at school?
- Under what circumstances should 911 be called if there is seizure activity at school?
- Does your child have a prescription for emergency rescue medication? If so, under what circumstances should the emergency medication be administered?
- Is there any other at home treatment used for your child's seizures such as medication, special diet, vagal nerve stimulator, or other?

Please share any other information you would like to share related to your child's seizure disorder: