BLUE SPRINGS R-IV SCHOOL DISTRICT
SEIZURE DISORDER INFORMATION SHEET

Student Name:	D.O.B:	School Year:	Grade:
Date or age of diagnosis:	Doctor:	Phone:	

TYPE OF SEIZURE (Please Check Below)

Generalized Seizures:

☐ Absence (Petit Mal)	☐ Atonic	☐ Myoclonic	☐ Tonic Clonic (Grand Mal)

Partial Seizures:

☐ Simple Partial (consciousness is retained)	☐ Complex Partial (consciousness is impaired/lost)
Current Medication:	Dosage:

☐ Yes	☐ No	Has your child been treated for seizures in the emergency room and/or hospitalized for seizures in the last 2 years?

When was your child's last seizure?

☐ Yes	☐ No	Does your child show any symptoms before a seizure? If yes, please explain:

Describe your child's seizure:

☐ Yes	☐ No	Does your child need special considerations related to his/her seizures while at school? Please describe:

Emergency Medical Services (911) will be contacted if student has respiratory distress and/or stops breathing, seizure lasts longer than 5 minutes, has repeated seizures without regaining consciousness, if it is student's first seizure, student has diabetes or is pregnant, seizure occurs in water, evidence of student injury, student cannot be awakened and is unresponsive to pain after seizure ends, pupils are not equal in size after seizure, or parent/guardian requests emergency evaluation.

Parent/Guardian Signature	**Date**