



MANHEIM TOWNSHIP SCHOOL DISTRICT

Health Services

Seizure Form for school year _____

Name: _____ DOB: _____ Date: _____

Seizure Information

1. When was your child diagnosed with seizures or epilepsy? _____
2. Seizure Type(s): _____

Seizure Type	Length	Frequency	Description

3. What might trigger a seizure in your child? _____
4. Are there any warnings and/or behavior changes before the seizure occurs? If YES, please explain _____
5. When was your child's last seizure? _____
6. How does your child react when a seizure is over and how long does the postictal state last? _____

Basic First Aid Care and Comfort

7. What basic first aid procedures should be taken for your child when they have a seizure in school? _____

Seizure Emergencies

8. Please describe what constitutes an emergency for your child: _____

Seizure Medication and Treatment Information

9. What medication does your child take?

*Medication	Dosage	Route	Frequency	Time of day

***If any of these medications are to be administered at school, your child's medical provider MUST complete and sign this form.**

Parent Signature _____ Date: _____

Medical Provider _____ Date: _____