Shorecrest | Be More

Shorecrest Preparatory School
Seizure/Epilepsy Student Health History

Name:_____ **DOB:**_____

Grade: _____ **Allergies:** _____

Parent/Guardian: _____ **Phone:**_____

Emergency Contact: _____ **Phone:**_____

Diagnosing/treating physician: _____ **Phone:**_____

Seizure Disorder / Epilepsy

Description of Condition: Seizure disorder or epilepsy is a condition where recurrent electrical charges disturb the normal functioning of the brain. There are several types of seizures that have different manifestations depending on the part of part of the brain that is affected. There are many causes for seizures that include: trauma, scars from old brain injuries, chemicals, inflammation of the brain, tumors, intoxication, and malformations. Seizures are not a disease but a symptom. A person is diagnosed with epilepsy if he/she has had more than two seizures unaccompanied by fever or illness and has an abnormal EEG.

Age seizures diagnosed _____ Abnormal EEG/date _____
Type of seizures: Grand Mal ☐ Absence (Petit Mal) ☐ Atonic (drop attacks) ☐ Febrile ☐
How often seizures occur? _____ When did last seizure occur_____
What do seizures look like? _____
Known triggers: _____
Special dietary needs or restrictions: _____

Please check behaviors/actions during seizure activity:

☐Loss of consciousness
☐Loss of bladder control
☐Body jerks
☐Slumps if sitting
☐Labored breathing
☐Pale or bluish complexion
☐Aura or warning
☐Stillness with staring
☐Repetitive behavior
☐Unaware of environment
☐Muscle stiffness and rigidity
☐Falls if standing
☐Screams or noise making
☐Bites tongue
☐Lip smacking
☐Dazed facial expression
☐Blinks
☐No memory of behavior
☐Incoherent speech

Other: _____
_____

Please check and explain behaviors that occur following seizure activity:

☐Sleep: Length of time student may sleep_____
☐Difficulty with arousal: _____
☐Other: _____

Student Name: _____ **DOB:**_____

MEDICATIONS: Include all medications taken every day and taken only as needed.

Name of Medication	Dose	Times Given	Side Effects

If your child is in medical distress and shows no signs of improvement and or emergency medication is given, 911 will be called.

I give permission for release of medical information contained in the Student Health History Form to be shared with school staff as needed, to maintain a healthy school environment for my child. I also give permission for the school nurse and Health Care Provider who is _____ and whose phone number is_____, to communicate verbally or in writing to provide continuity of care and safety for my child.

X_____ _____
Parent/Guardian's Signature Date

X_____ _____
Nurse's Signature Date