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Seizure Questionnaire

Created 4/28/2023

Seizure Info

Participant's Name: _____

History of Seizures? ☐ Yes ☐ No (If no, please skip to the end and sign and date)

Date of Last Seizure: _____ Seizure Type: _____

When were they diagnosed with seizures? _____

How often do they have a seizure? _____

How long does the seizure last? _____

Are they on medication to help with the seizures? ☐ No ☐ Yes

If yes, please explain: _____

Is there any pre-seizure behavior? ☐ No ☐ Yes

If yes, please explain: _____

Is there a typical motor activity during seizures? ☐ No ☐ Yes

If yes, please explain: _____

Is there any post-seizure behavior? ☐ No ☐ Yes

If yes, please explain: _____

What steps should the school teacher/paraprofessional take in the event a seizure should occur at our facility?

_____

_____

Legal Representative Signature: _____ Date: _____

Legal Representative Printed Name: _____