Seizure Questionnaire

(Rev. 8/26/20)

Please complete this form if the participant experiences seizures. **Please update this form whenever there is a change in the seizure information/plan and promptly submit it to NWCSRA.**

Participant's Name: _____

Completed by: _____ **Relationship:** _____ **Phone:** _____

1. Please describe a typical seizure: _____

   _____

   _____

2. What might trigger a seizure in your child?_____

   _____

3. Are there any warnings and/or behavior changes before the seizure occurs? _____

   _____

4. How frequently do seizures occur?

   □ Daily □ Weekly □ Monthly □ 1 per 3-6 months □ 1 per 6-12 months □ Annually

5. What was the date of your child's last seizure? ___/___/___

6. How long does the typical seizure last? _____

7. How does your child react after a seizure is over? _____

   _____

Type of Seizure(s) (Please check all that apply):

___Absence (staring spell/rapid blinking)
___Atonic (drop attack)
___Grand Mal (tonic-clonic)
___ Other (explain):_____
___ Simple Partial (twitching/change in sensation)
___ Complex Partial (confusion/dazed)

Seizure Response Plan

In the event of a perceived seizure, NWCSRA staff will follow basic first aid procedures for the care of seizures. Please list any additional actions you would like NWCSRA staff to take in the event of a seizure:

1. Call 911 for a seizure lasting more than _____ minutes. (Please Note: Depending on circumstances, NWCSRA staff may disregard this request and instead call 911 immediately)
2.
3.

Please note: NWCSRA staff will not administer rectal Diastat or perform any other invasive medical procedures.

Parent/Guardian Signature: _____ Date: _____
Please return this completed form to the NWCSRA office. (attn: Carrie Gascoigne)