RETURN TO SCHOOL NURSE **Bus # _____**

SURRY COUNTY SCHOOLS

SCHOOL HEALTH PROGRAM

School Seizure Record

School Year _____

Name of Student _____

School _____ **Grade** _____

Parent/Guardian _____ **Phone** _____

_____ **Phone** _____

Physician _____ **Phone** _____ **Hospital** _____

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1. **What type of seizures does your child have and how often do they occur?**

   _____

   _____

2. **Describe your child's symptoms during and after the seizure episode** _____

   _____

   _____

3. **Does your child have an aura or warning of seizure coming? Is he/she able to notify anyone that a seizure is coming?** _____

   _____

   _____

4. **Name medications taken routinely. How often and how much?**

   At home? _____

   At school? _____

5. **Does your child suffer any side effects to these medications? If so, please list:**

   _____

   _____

6. **Are there any sports/activities in which your child <u>cannot</u> fully participate?**

   _____

   _____

7. **What steps do you want school personnel to take if a seizure should happen?** _____

   _____

   _____

(OVER)