

| SEIZURE HISTORY  |   |
|--|---|
| What type of seizures does your child experience (generalized, partial, absence)?      | How often does your child experience seizures?    |
|  | When was your child's last seizure?               |
| How long do seizures typically last for your child?                                    | When was your child's last neurology appointment? |
|  | Who is your child's neurologist?                  |
| What medication does your child take daily for seizures:                               | Was your child's most recent EEG abnormal?        |
|  | Does your child have a VNS?                       |
| Does your child have emergency medication for seizures?                                | Does your child have a VNS?                       |
| Is there anything else you believe we should know about your child's seizure disorder? |   |
| Parents Signature:   | Date:   |



|                 |
|-----------------|
| Student's Name: |
| DOB:            |