Dear Parent,

According to your child's health record, he/she has a history of seizures. Please complete the information below and return it to the school nurse. Thank you.

Child's Name: ____

Physician: ____Phone:__________________________

1. What medication is your child currently taking?

2. What side effect, if any, does your child experience from the medication?

3. When and how did you learn of your child's seizure disorder?

4. Has your child ever had a seizure that lasted more than 5 minutes?

5. How do you handle seizures occurring at home?

6. How do you want us to handle seizures occurring at school?

7. When was your child's last seizure?

8. Approximately how often does your child experience seizures?

Comments and special instructions.

____

____

____

____

_________________________________ _________________

Parent signature Date