

**VISION ACADEMY CHARTER SCHOOL
SEIZURE DISORDER CHECKLIST**

1. Name of student _____ Grade _____ Teacher _____
2. Physician treating the seizure disorder: _____
Phone : _____
3. What type of seizures does your child have?

4. Age at the time of diagnosis _____
5. What medications are taken to control seizure activity?
Name _____ Dose _____ Time(s) _____
Name _____ Dose _____ Time(s) _____
Name _____ Dose _____ Time(s) _____
6. What is the date of the last seizure

7. How often do seizures occur? _____
8. Does your child know when he/she is about to have a seizure? Yes ___ No ___
9. What, if any, are signs that a seizure is about to occur?

10. What happens during a seizure? _____
11. What happens immediately following a seizure? _____
12. What treatment should your child receive in school? _____
13. What, if any, are restrictions on activity? _____
14. Other comments:

Signature _____ Date _____