SEIZURE INFORMATION FORM

Valid March 1, 2023 - May 31, 2024

Participants with a history of seizure must complete this form and return a signed copy of a seizure plan from their doctor if applicable. This form should be updated whenever there are changes to the seizure plan, medications, etc., and on an annual basis .

PARTICIPANT INFORMATION

Participant Name _____ **Birthdate** _____

Parent/Guardian Name _____ **Emergency Contact Name** _____

Cell Phone _____ **Cell Phone** _____

Home Phone _____ **Home Phone** _____

SEIZURE INFORMATION

Has the participant ever had a seizure? ☐ No ■ Yes

Does the participant have a Seizure Plan created by a medical professional? If yes, please email a copy of the plan to info@fvsra.org ☐ No ☐ Yes

What type of seizures does the participant have? (Check all that apply)

☐ Complex Partial Seizure ☐ Drop Seizure ☐ Grand Mal / Generalized Tonic-Clonic Seizure

☐ Simple Partial Seizure ☐ Myoclonic Seizure ☐ Petit Mal / Absence Seizure

☐ Unknown ☐ Other _____

Please provide a description of the seizure:

_____

_____

Are there any symptoms, triggers, and/or auras prior to the onset of the seizure? ☐ No ☐ Yes
If yes, please describe.

_____

_____

How frequently do seizures occur?

☐ Daily

☐ Weekly

☐ Monthly

☐ 1 - 6 times per year

☐ No seizures in a year or more

What was the duration of the participant's longest seizure?

☐ Less than 1:00 minute

☐ 1:00 - 1:59 minutes

☐ 2:00 - 2:59 minutes

☐ 3:00 - 3:59 minutes

☐ 4:00 - 4:59 minutes

☐ 5:00 - 10:00 minutes

☐ 10:00 - 30:00 minutes

☐ Longer than 30 minutes

Describe the participant's typical post-seizure condition (lethargic, confused, etc.)

_____

_____

Does the participant have a Vagal Nerve Stimulator (VNS)? If yes, describe instructions for appropriate magnet use and if the magnet will be passed on to Program Leader for use during programs. If the magnet is no longer used as an intervention, write N/A. ☐ No ☐ Yes

_____

_____

List any emergency medication to be used during and/or following a seizure (include medication name, dosage, and possible side effects).
NOTE: FVSRA will call 911 at onset of perceived seizure for anyone who utilizes emergency medication for seizures. FVSRA cannot administer rectal or injectable medication and cannot administer any emergency nasal or oral medication during the seizure (e.g. Diastat, Nasal Versed, Lorazepam). Upon request, FVSRA will hold and pass these medications to EMS/hospital staff in the case of an emergency.

_____

SEIZURE RESPONSE PLAN

FVSRA policy is to call 911 after 3 minutes of perceived continuous seizure activity (or sooner if staff determine necessary). If you would prefer Emergency Medical Services (EMS) called at the initial perceived onset of the seizure, check "Yes." ☐ No ☐ Yes

List any additional steps you would like taken in the event of an emergency. If not applicable, type N/A

_____

Name of person completing this form _____ **Signature** _____

Relationship to Participant _____ **Date** _____