Western High School – Health Office
(714)220-4048 fax: (714)220-4027
Email: lowe_r@auhsd.us

ORANGE COUNTY DEPARTMENT OF EDUCATION
SEIZURE HISTORY

STUDENT _____ DATE OF BIRTH _____

SCHOOL _____ DATE COMPLETED _____

School records indicate your child has a seizure disorder. The school is requesting the following information so we can better assist your child should a seizure occur at school. Immediate care may be of an emergency nature.

Please answer the following questions and return to school as soon as possible:

1. Seizure type: _____

2. Describe the seizures: _____

_____

3. Average length of time seizure lasts _____

4. How often seizures occur _____

5. Describe student's behavior following a seizure _____

6. What will trigger a seizure? _____

7. List any warning signs before the seizure _____

8. Please list any medications your child receives _____

Name of medication _____ Dose/Time given _____

Name of medication _____ Dose/Time given _____

Name of medication _____ Dose/Time given _____

Name of medication _____ Dose/Time given _____

9. Physician's Name _____ Telephone # _____

10. Additional Comments: _____

_____

_____

_____ _____

Parent Signature Date Principal Signature Date

_____ _____

School Nurse Signature Date Teacher Signature Date

NOTE: Parents are responsible to notify school nurse if medication/seizure information changes.