18.2

|  |
| --- |
| SRSNLC Seizure Questionnaire |
|  Please complete this form if the participant has ever experienced a seizure. **Please update this form whenever there is a change in the seizure plan and submit with your registration.** You will be asked to review this once a year and provide any necessary updates. |
|
|  |
| Participant’s Name: |  |
| Parent/Guardian: |  |  | Phone |  |
| Emergency Contact: |  |  | Phone: |  |
|  |
| **Please note: SRSNLC will not administer rectal diastat.** |
|  |
| Seizure Type: |
| [ ]  | Absence (staring spell) |  | [ ]  | Atonic (drop) |  |
| [ ]  | Simple Partial |  | [ ]  | Generalized (grand-mal) |  |
| [ ]  | Complex Partial |  | [ ]  | Other (Explain): |  |
|  |
| When was the date of your/your child’s last seizure? |  |
| How long does the seizure last? |  |
| How long was the longest seizure? |  |
|  |
| Are there any triggers that cause the onset of your/your child’s seizures? (I.E. strobe lights, heat, sudden movements, noise) |
| Explain: |  |
| Are there any symptoms prior to the onset of your/ your child’s seizure? (I.E. smells, stomach pain, fear, sounds) |
| Explain: |  |
|  |
| **Seizure Plan** |
| Please list below the necessary steps you would like SRSNLC to take in the event of a seizure: |
| 1. | Call 911 for a seizure over |  | minutes. |
| 2. |  |
| 3. |  |
|  |
| **Parent/Guardian Signature:** |  | **Date:** |  |
|  |
| It is important that we follow a consistent procedure for responses to seizures, therefore if your child has a seizure plan in place for school/ workshop/ prescribed by a doctor, a copy of that should be submitted in addition to this form.  |