NISRA
Northern Illinois Special Recreation Association

Office use only:
Date Reviewed: _____
Initial: _____

Seizure Questionnaire

(Rev. 1/31/2017)

Please complete this form if the participant experiences seizures. **Please update this form whenever there is a change in the seizure information/plan and promptly submit it to NISRA.** NISRA requests that you review this form once a year and provide any necessary updates.

Participant's Name: _____

Completed by: _____ **Relationship:** _____ **Phone:** ( ) _____

Medication(s):
Participant medication needs are to be noted on their *Annual Information Update* form which is distributed each year in the summer & fall seasonal brochures. If the participant's medication needs have changed since submission of their *Annual Information Update* form, please submit a new update as soon as possible.
A *Medication Permission* form must be submitted if you are requesting NISRA staff to assist with the dispensing of scheduled oral or topical maintenance medication. To obtain a copy of the *Annual Information Update* form or *Medication Permission* form, please contact the NISRA office or download a copy of the forms from the NISRA website at www.nisra.org and click on the "Dates & Forms" tab.

Please note: NISRA staff will not administer rectal Diastat or perform any other invasive medical procedures.

1. Please describe a typical seizure: _____
   _____
   _____
2. Are there any symptoms prior to the onset of the seizure? (i.e. smells, stomach pain, fear, sounds, etc.)
   _____
3. What was the date of the participant's last seizure? ___/___/__
4. How long does the typical seizure last? _____

Type of Seizure(s) (Please check all that apply):

___ Absence (staring spell) ___ Atonic (Drop) ___ Simple Partial
___ Complex Partial ___ Generalized (Gran Mal)
___ Other (explain):_____

Seizure Response Plan

In the event of a perceived seizure, NISRA staff will follow basic first aid procedures for the care of seizures. Please list any additional actions you would like NISRA staff to take in the event of a seizure:

1. Call 911 for a seizure lasting more than _____ minutes. (Please Note: Depending on circumstances, NISRA staff may disregard this request and instead call 911 immediately)
2.
3.

☐ **VNS Device Check box**: If checked, parent/guardian must train staff on use of VNS device.

Parent/Guardian Signature: _____ **Date:** _____
Please return this completed form along with your Registration Form to the NISRA office.