Seizure Questionnaire

(Rev. 5/29/18)

Office use only:
Date Reviewed: _____
Initial: _____

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 SRACLC.** SRACLC 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 Form* which is distributed each year in the seasonal brochures. If the participant's medication needs have changed since submission of their *Annual Information Form*, please submit a new update as soon as possible. **A *Medication Dispensing* form must be submitted if you are requesting SRACLC staff to assist with the dispensing of scheduled oral or topical maintenance medication.** To obtain a copy of the *Annual Information Form* or *Medication Dispensing* form, please contact the SRACLC office or download a copy of the forms from the SRACLC website at www.sraclc.org, click on the "Program" then "Registration" tabs.
Please note: SRACLC 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 (Grand Mal)
☐ Other (explain):_____

Seizure Response Plan

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

1. Call 911 for a seizure lasting more than _____ minutes. (Please Note: Depending on circumstances, SRACLC staff may disregard this request and instead call 911 immediately. 911 will be called for any seizure lasting longer than five (5) minutes.)
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 to the SRACLC office.
290 Oakwood Rd. Vernon Hills, IL 60061, info@sraclc.org, or fax 847-816-4876.