

# McHenry School District 15

1011 N. Green Street

McHenry, IL 60050

www.d15.org

## Information Form For The Student With a Seizure Disorder

School: \_\_\_\_\_

Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

Telephone: \_\_\_\_\_

Physician/Health Care Provider: \_\_\_\_\_

## Medical Information

Seizure Type: \_\_\_\_\_

Description of seizure: \_\_\_\_\_

Possible triggers: \_\_\_\_\_

Average length of time of seizure: \_\_\_\_\_

Possible warning and/or behavior changes prior to seizure: \_\_\_\_\_

Student's reaction to the seizure: \_\_\_\_\_

\_\_\_\_\_

## Medical Procedures

First Aid Procedures: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Limitations specified by physician: \_\_\_\_\_

Likelihood and frequency of seizures during school hours: \_\_\_\_\_

\_\_\_\_\_

## Parent's Information

Parent's Comments: \_\_\_\_\_

\_\_\_\_\_

## Medication

The student is receiving the following treatment to control the seizure(s):

Name of Medication: \_\_\_\_\_ Name of Medication: \_\_\_\_\_

\_\_\_\_\_

Amount/time given: \_\_\_\_\_ Amount/time given: \_\_\_\_\_

\_\_\_\_\_

Possible side effects: \_\_\_\_\_ Possible side effects: \_\_\_\_\_

\_\_\_\_\_

## Parent's Signature

\_\_\_\_\_  
(PARENT SIGNATURE)

\_\_\_\_\_  
(DATE)

## Staff Members

The following staff members have reviewed the above procedures:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_