NWCA Head Start/Early Head Start
312 N. Main P.O. Box 67
Badger, MN 56714
218-528-3227 800-568-5319

Seizure Record

Last Name	First	Middle	Birth Date

Physician treating child's seizures: Name_____ Telephone #_____

1. When was your child's first seizure?

2. Have these seizures continued? ☐ yes ☐ no
   How often?

3. Are the seizures controlled by medication at this time? ☐ yes ☐ no
   If yes, a **Medication Permission Form** is required.

4. Are the seizures related to an illness, fever, time of day, stress, hunger or environmental factors, i.e., lights, physical location? ☐ yes ☐ no
   If yes, describe.

5. What behavior or symptoms occur at the following times?

   Before the seizure:

   During the seizure:

   After the seizure:

6. Has a physician ever diagnosed (given a name to) the **type** of seizure your child experiences?
   ☐ yes ☐ no
   If yes, list type.

7. What situations or activities help prevent the seizure?

8. What, if any, special instructions do you have if your child has a seizure?

Parent Signature _____ Date _____