

Name _____ Age _____

MEDICAL CONCERNS
Seizures

My child has had _____ seizures in his/her lifetime.

The main cause for the seizures is (if unknown, please state) _____

Most seizures my child has are: petit mal grand mal

What elements trigger seizures in your child?

- Lights Loud noise High activity level
- Medication change Diet change Lack of sleep Too much sleep
- Scents (please list) _____
- Foods (please list) _____
- Other _____ Other _____
- Other _____ Other _____
- Other _____ Other _____

Warning signs of seizure activity:	What to do during the seizure activity (place pillow under head, leave child alone, etc.)	What to do immediately following the seizure activity

***Please note: This form is for use of gathering additional information and does not replace any required licensing forms.**