



SRSNLC SEIZURE QUESTIONNAIRE

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 SRSNLC.** SRSNLC 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 **Winter/Spring** program guide. 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 SRSNLC 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 your local SRSNLC office or download a copy of the forms from your local SRSNLC website.

Please check box & sign below if participant has not experienced a seizure in the last 5 years.

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

1. Call 9-1-1 for a seizure lasting more than _____ minutes. (Please Note: Depending on circumstances, SRSNLC staff may disregard this request and instead call 9-1-1 immediately)
2. _____
3. _____

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

Signature of Parent/Guardian: _____ **Date:** _____

Please return this completed form along with your Registration Form to your local SRSNLC office.