2017 SEIZURE FORM (annual)
LINCOLNWAY SPECIAL RECREATION ASSOCIATION

According to your registration form, the below named participant has a history of seizures. In order for staff to more effectively respond to seizure activity, it is necessary to provide information regarding the seizures. Please fill out this form completely and return to LWSRA. This form is good for the calendar year so only needs to be updated with your first registration for that year OR whenever information changes.

Name: ____ Date: ______________________

This form is completed by: ___________________________ Relationship: ____________________

1. How frequently do seizures occur? ____
2. Please describe the characteristics of the seizures: _______________________________________

   ____
3. What is the usual duration of the seizure? ____

   ____
4. What actions do you take in the event of a seizure? ______________________________________

   ____
5. When do seizures normally occur? Is there a pattern or warning signal? _______________________

   ____
6. Please describe how he/she reacts after a seizure: _______________________________________

   ____

   ____
7. What medication is he/she currently prescribed? _______________________________________

   ____
8. Name and phone number of physician who prescribed the medication:

   Name: ____________________________________ Phone: __________________________
9. Are there side effects to the medication? If so, what are they? ______________________________

   ____
10. In case of a seizure, you will be notified. Please list all contact numbers: ________________________

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Please know that if there are any medical concerns (including, but not limited to, Grand Mal seizure), 911 will be called.