

2019 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: _____

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