2020 SEIZURE FORM

WHO SHOULD COMPLETE THIS FORM?

LWSRA requires any participants with a history of seizures to complete a seizure form annually. This form allows staff to more effectively respond to seizure activity. Please fill out this form completely and return to LWSRA. Forms may be filled in digitally in Adobe Reader and emailed to support@lwsra.org.

PARTICIPANT INFORMATION (PLEASE PRINT)

First & Last Name:_____ **Date of birth:**_____ / _____ / _____

Form is being completed by: _____ **Relationship:**_____

SEIZURE HISTORY

How frequently do seizures occur?_____ **Usual duration:**_____

What are the charecteristics of the seizures? *(please describe)*	
What actions do you take in the event of a seizure? *(please describe)*	
When do seizures normally occur? (Patterns/Warning signs) *(please describe)*	
How do they react after a seizure? *(please describe)*	

MEDICAL

Doctor's Name _____ **Doctor's Phone** _____ **Hospital Affiliation** _____

1 Medication (name, dose & frequency)_____

2 Medication (name, dose & frequency)_____

3 Medication (name, dose & frequency)_____

Please describe any side effects of the medication	

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

ACTIONS STEPS (please list steps you would like LWSRA staff to take in the event of a seizure)

Note: If there are any medical concerns 911 will be called (including but not limited to Grand Mal seizure)

Step 1:_____

Step 2:_____

Step 3:_____

Step 4:_____

If any of this information changes please notify the LWSRA office and complete an updated form if necessary