2019 Seizure Questionnaire

Please complete this form if the participant experiences seizures. You will be asked to review this once a year and provide any necessary updates. **For the safety of the participant you are requested to update this form whenever there is a change in the seizure information or plan and promptly submit it to WDSRA.** Mail or scan and email to: registration@wdsra.com

Participant's Name: _____

Completed by: _____ Relationship: _____ Phone: (_____) _____

Seizure Type (Please check):

___Absence (Staring Spell) ___Complex Partial ___Simple Partial

___Atonic (Drop) ___Generalized (Grand Mal) ___Other (Explain):_____

_____

1. What was the date of the participant's last seizure? _____/_____/_____
2. How frequently do seizures occur? ___Daily ___Weekly ___Monthly ___1 Per 3-6 Mo ___1 Per 6-12 Mo ___Annually ___Controlled
3. How long does the typical seizure last?_____
4. Are there any symptoms prior to the onset of the seizure? (i.e. smells, stomach pain, fear, sounds, etc.) _____

   _____
5. Please describe a typical seizure:_____

   _____
6. Describe Seizure Recovery. How does participant react after a seizure? _____

   _____

Seizure Plan

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

1. Call 911 for a seizure lasting more than ☐ minutes. (**Please note**: Depending on circumstances, WDSRA staff may disregard this request and instead call 911 immediately)
2. _____
3. _____

☐ **Vagus Nerve stimulations Device (VNS) Check box**: If checked, parent / guardian MUST train staff on use of device.

Medication(s):

Participant medication needs are to be noted on their *Annual Information Form*. If the participant's medication needs have changed since submission of their *Annual Information Form*, please submit a new update as soon as possible.

A *Medication Permissio*n *Waiver Form* **must be submitted if you are requesting WDSRA staff to assist with the dispensing of scheduled oral or topical maintenance medication.** To obtain a copy of the *Annual Information Form* or *Medication Permission Waiver Form*, please contact the WDSRA office or download a copy of the form(s) from the WDSRA website at www.wdsra.com and click on the "Schedules and Forms" tab. *PLEASE NOTE: WDSRA staff will not administer Diazepam, Valium, Versed, rectal Diastat or oral rescue medicines.*

Parent/Guardian Signature:_____ Date: _____/_____/_____

Please return this completed form along with your Registration Form to the WDSRA office.