POMONA UNIFIED SCHOOL DISTRICT
HEALTH SERVICES & PROGRAMS
Seizure Disorder Health History

To the Parents of : _____ Date: _____

According to school records, your child has a seizure disorder. The school needs the following information so we can be ready to assist your child in case of a seizure. Immediate care may be of an emergency nature. Please complete the following information and return this form to the School Nurse. Thank you.

Parent/Guardian: _____ Home # _____ Work # _____
Physician /City: _____ Phone _____
Name of Health Insurance: _____

1. At what age did the first seizure occur? _____
   Was it following a high fever? _____ Yes _____ No.
   Was it in connection with illness? _____ Yes _____ No
   If yes, please explain: _____
   _____
2. Approximate date of last seizure: _____
3. How frequently does your child have seizures? _____
4. Describe the seizure _____
   _____
5. Approximately how long does a seizure last? _____
6. What will trigger a seizure? _____
   Are there warning signs? _____
7. Describe your child's behavior following the seizure _____
   _____
8. Do you have medication at home to prevent/control the seizures? _____ Yes _____ No
   Name of medication(s) _____ _____
   Dosage of medication _____ _____
   Time medication is given _____ _____
9. When was your child last seen by a physician for his/her seizure disorder? _____

_____ Parent/Guardian

_____ Date

_____ School Nurse

_____ Date

PLEASE RETURN THIS FORM TO THE SCHOOL HEALTH OFFICE

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