



2018 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 Permission 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 "Links" tab. **PLEASE NOTE: WDSRA staff will not administer Diazepam, Valium, Versed or rectal Diastat.**

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

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