Cypress High School – Health Office
(714)220-4192 fax: (714)220-3058
Email: binford_k@auhsd.us

ORANGE COUNTY DEPARTMENT OF EDUCATION
SEIZURE HISTORY

STUDENT ___________________________________ DATE OF BIRTH _____________________

SCHOOL _____________________________________ DATE COMPLETED _________________

School records indicate your child has a seizure disorder. The school is requesting the following information so we can better assist your child should a seizure occur at school. Immediate care may be of an emergency nature.

Please answer the following questions and return to school as soon as possible:

1. Seizure type: ____

2. Describe the seizures: ____

____

3. Average length of time seizure lasts ____

4. How often seizures occur ____

5. Describe student's behavior following a seizure ____

6. What will trigger a seizure? ____

7. List any warning signs before the seizure ____

8. Please list any medications your child receives ____

Name of medication _______________________________ Dose/Time given _____________

Name of medication _______________________________ Dose/Time given _____________

Name of medication _______________________________ Dose/Time given _____________

Name of medication _______________________________ Dose/Time given _____________

9. Physician's Name _______________________________ Telephone # _____________________

10. Additional Comments: ____

____

____

_____________________________________ _____________________________________
Parent Signature Date Principal Signature Date

_____________________________________ _____________________________________
School Nurse Signature Date Teacher Signature Date

NOTE: Parents are responsible to notify school nurse if medication/seizure information changes.