**Seizure Detail Form**

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| **Participant Name:** | **Date of Birth:** |
| **Parent/ Guardian:** | **Primary**  **Phone Number:** |
| **Other Emergency Contact:** | **Emergency Contact**  **Phone Number:** |
| **Treating Physician:** | **Physician**  **Phone Number:** |
| **Significant Medical History** | |

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| --- | --- | --- | --- |
| **Date of last seizure:** | | | |
| **Seizure Type** | **How long does a seizure typically last?** | **How often do seizures occur?** | **Description of seizure** |
|  |  |  |  |
| **Seizure triggers or warning signs:** | | | |
| **Response after a seizure:** | | | |
| **Additional comments:** | | | |

Parent/ Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_