**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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_