

Seizure Detail Form

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	

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: _____