LEXINGTON SCHOOL DISTRICT ONE

Empower each child to design the future.

Dear Parent,

According to your child's health record, he/she has a history of seizures. Please complete the information below and return it to the school nurse. Thank you.

Child's Name: _____

Physician: _____Phone:_____

What medication is your child currently taking? _____

_____

What side effect, if any, does your child experience from the medication?_____

_____

When and how did you learn of your child's seizure disorder? _____

Has your child ever had a seizure that lasted more than 5 minutes?_____

How do you handle seizures occurring at home?_____

How do you want us to handle seizures occurring at school?_____

When was your child's last seizure?_____

Approximately how often does your child experience seizures?_____

Comments and special instructions.

_____

_____

_____

_____

_____ _____

Parent signature Date