



# Meeting Street

believing in the possibilities

## Seizure Description Form

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

**Student's Name:** \_\_\_\_\_ **D.O.B.:** \_\_\_\_\_ **Age:** \_\_\_\_\_

Does your child have seizures? Yes \_\_\_\_\_ No \_\_\_\_\_

Type of seizures: \_\_\_\_\_

Describe any seizure activity:

How often do they occur?

How long do they last?

What emergency measures are needed, if any?

What medications or treatments is your child receiving for seizures?