Olton ISD
Seizure History Form

Student Name:_____ **DOB:**_____ **Grade:**_____

Homeroom Teacher:_____

(1) **Emergency Contact Name/Number**:_____

(2) **Emergency Contact Name/Number:**_____

Physician Name/Number:_____

Clinic Address:_____

Last time student was seen by physician?_____

When were you diagnosed with seizures/epilepsy?_____

Do you have any signs/symptoms before a seizure starts?

_____

What do you do at home after a seizure?

_____

What medications are you currently taking to control your seizures?

Medication Name	Dose	Frequency	Administer at school?

1. Are you knowledgeable about your medication? **Yes No**
2. Do you know when you need your medication? **Yes No**
3. Does your child require medication at school? **Yes No**
4. Does your child have emergency medication? **Yes No**

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If yes to #3 or #4, the attached *Medication Authorization Form* must be completed and returned to the school nurse with the medication. The medication must be in the original labeled container and must always have a current prescription label.

Please thoroughly complete the attached *Seizure Action Plan* form. This will allow the school nurse to complete an IHP (care plan) for your student to ensure that staff is able to provide the best care to your student if and when needed.

Parent/Guardian Authorization

I request that the above medication be administered during school hours as ordered by the student's physician. I request that medications be given on field trips or other school sponsored activities, as prescribed. I release school personnel from liability in the event adverse reactions result from taking the medication(s). I will notify the school of any change(s) in medication(s). I give permission for the school nurse to communicate with the student's teachers and physician about my child's seizures.

_____	_____	_____
Parent/Guardian Name	**Parent/Guardian Signature**	**Date**