2017 WDSRA Seizure Questionnaire

Please complete this form if the participant experiences seizures. You will be asked to review this once a year and provide any necessary updates. **For the safety of the participant you are requested to update this form whenever there is a change in the seizure information or plan and promptly submit it to WDSRA.** WDSRA Fax # 630-681-1262.

Participant's Name: _____

Completed by: _____ **Relationship:** _____ **Phone:** (_____) _____

Seizure Type (Please check):

___Absence (Staring Spell) ___Complex Partial ___Simple Partial

___Atonic (Drop) ___Generalized (Grand Mal) ___Other (Explain):_____

1. What was the date of the participant's last seizure? ____/____/_____
2. How frequently do seizures occur? ___Daily ___Weekly ___Monthly ___1 Per 3-6 Mo ___1 Per 6-12 Mo ___Annually ___Controlled
3. How long does the typical seizure last?_____
4. Are there any symptoms prior to the onset of the seizure? (i.e. smells, stomach pain, fear, sounds, etc.) _____
5. Please describe a typical seizure:_____
6. Describe Seizure Recovery. How does participant react after a seizure? _____

Seizure Plan

In the event of a seizure, WDSRA staff will follow basic first aid procedures for the care of seizures. Standard First Aid is to call 911 for seizures when it is someone's first seizure or any seizure that lasts longer than 5 minutes. Please list any additional steps you would like WDSRA staff to take in the event of a seizure:

1. Call 911 for a seizure lasting more than ____ minutes (fill in the box with preferred amount of time). Based on participant's needs & seizure style, guardians may have a preferred amount of time that is less than OR more than 5 minutes to call 911.
2. _____
3. _____

Medication(s):
Participant medication needs are to be noted on their *Annual Information Form*. If the participant's medication needs have changed since submission of their *Annual Information Form*, please submit a new update as soon as possible.

A *Medication Permission Waiver Form* must be submitted if you are requesting WDSRA staff to assist with the dispensing of scheduled oral or topical maintenance medication. To obtain a copy of the *Annual Information Form* or *Medication Permission Waiver Form*, please contact the WDSRA office or download a copy of the form(s) from the WDSRA website at www.wdsra.com and click on the "Links" tab. ***PLEASE NOTE:*** *WDSRA will not administer rectal Diastat, Diazepam or Valium.*

Parent/Guardian Signature:_____ **Date:** ____/____/_____

Please return this completed form along with your Registration Form to the WDSRA office.