FOUNTAIN VALLEY SCHOOL DISTRICT
10055 Slater Ave. Fountain Valley, CA 92708 714.843.3200 www.fvsd.us

ANNUAL SEIZURE QUESTIONNAIRE FOR PARENTS

School Year: _____ School: _____ Grade: _____ Date: _____
Student Name: _____ Birth Date: _____Teacher: _____
Parent/Guardian: _____ Phone: _____ Cell: _____
Parent/Guardian Email: _____
Physician: _____Telephone: _____ Fax: _____

Trigger/s	
Warnings	
Behavioral changes	

1. Within the past 12 months, has your child experienced a seizure/epilepsy? ☐ Yes ☐ No

2. If yes, has your child's seizure presentation changed over the past 12 months? ☐ Yes ☐ No

3. Please provide the date, time, type and duration and any change/s in your child's seizure/s or recovery pattern (how your child acts after the seizure) over the past 12 months:

Date	Seizure Type	Length	Frequency	Location	Description

4. When did your child experience their last seizure? _____

5. Has your child experienced any changes before a seizure? If yes, describe the changes:

Trigger/s	
Warnings	
Behavioral changes	

6. Has there been a change in medication over the past 12 months? ☐ Yes ☐ No

7. If yes please update this medication area.

Medication	Dose	Time	Date started	Reason for medication	Possible side effects