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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Student Name: | | | | | | | | | | | | | |
| Sex: M or F | | Date of Birth: | | | | | | Date of Entry: | | | | | |
| Type of Seizure Disorder: | | | | | | | | | | | | | |
| Co-Morbid Conditions: | | | | | | | | | | | | | |
| Medications on Entry: | | | | | | | | | | | | | |
| **Seizure disorder EPISODE** | | | | | | | | | | | | | |
| Date | Time | | Length of Seizure | | | Events before seizure | | | | Description of seizure and events after seizure | | | |
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| MEDICATION MANAGEMENT | | | | | | | | | | | | | |
| **Date Prescribed** | **Medication and Dosage** | | | **Date Changed** | | Comments | | | | | | | |
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| SEIZURE DISORDER MANAGMENT | | | | | | | | | | | | | |
| **Every Visit or as indicated** | **Date** | | |  |  | |  | |  | |  |  |  |
| **Hearing loss or vision concerns** | | |  |  | |  | |  | |  |  |  |
| **Neuromotor problems** | | |  |  | |  | |  | |  |  |  |
| **Fecal or urinary incontinence** | | |  |  | |  | |  | |  |  |  |
| **Sleep disorder** | | |  |  | |  | |  | |  |  |  |
| **Medication side effects** | | |  |  | |  | |  | |  |  |  |
|  | **Driving**  **YES or NO** | | |  |  | |  | |  | |  |  |  |