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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 |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
| 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** |  |  |  |  |  |  |  |