**Special Recreation Services**

1624 E. 154th Street, Dolton IL 60419

(708) 207-9141 Phone (708) 841- 1053 Fax

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Special Recreation Services Seizure Questionnaire

Please complete this form if the participant experiences seizures, or return a copy of your child’s seizure plan from his/her school. ***Please update this form whenever there is a change in the seizure plan and submit it with your registration.*** You will be asked to review this once a year and provide any necessary updates.

Participant’s Name: ­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Medication:

Name: Dosage: Time of intake:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Seizure type (please check):

\_\_ Absense(staring spell)

\_\_ Simple Partial \_\_ Atonic (drop)

\_\_ Complex Partial \_\_ Generalized (Grand Mal)

\_\_ Other (please explain): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What was the date of the participant’s last seizure? \_\_\_/\_\_\_/\_\_\_\_

How long did the seizure last? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long was the longest seizure? \_\_\_\_\_\_\_\_\_\_\_\_\_

Are there any symptoms prior to the onset of the seizure? (i.e., smells, stomach pain, fear, sounds, etc.)

Please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Seizure Plan**

Please list the necessary steps you would like SRS to take in the event of a seizure:

1. SRS staff will call 911 after 3 minutes, per agency policy.
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Please return this completed form, or other seizure plan, along with your Registration Form to the SRS office.**