Putting People First
NEDSRA
Special Recreation Association
1770 W. Centennial Place, Addison, IL 60101-1076
Phone 630.620.4500 Fax 630.620.4598 www.nedsra.org

Seizure Questionnaire

Please complete both sides of this form if the participant experiences seizures. **This form must be updated when there is a change in the seizure information/plan and promptly submitted to NEDSRA.** NEDSRA requests that you review this form once a year and provide any necessary updates.

Participant's Name: ____

Completed by:________________________ **Relationship:**_____________ **Phone:**________________________

Medication(s):
Participant medication needs are to be noted on their *Annual Information Form*, which is distributed each year. If the participant's medication needs have changed since submission of their *Annual Information Form*, an updated form must be submitted as soon as possible.

A *Medication Release Form* must be submitted if you are requesting NEDSRA staff to assist with the dispensing of scheduled oral or topical maintenance medication. To obtain a copy of the *Annual Information Form* or *Medication Release Form*, please contact the NEDSRA office or they are available on the NEDSRA website.

Please note: NEDSRA staff will not administer rectal Diastat or perform any other invasive medical procedures.

1. Please describe a typical seizure:

2. Are there any symptoms prior to the onset of the seizure? (i.e. smells, stomach pain, fear, sounds, etc.)
   Yes No If yes, please describe.

3. What was the date of the participant's last seizure? ___________________________

4. How long does the typical seizure last? _____________________________________

Type of Seizure(s) (Please check all that apply):

Absence (staring spell) Atonic (Drop) Simple Partial

Complex Partial Generalized (Gran Mal)

Other (explain):

Seizure Response Plan
In the event of a perceived seizure, NEDSRA staff will follow basic first aid procedures for the care of seizures. Please list any additional actions you would like NEDSRA staff to take in the event of a seizure:

1. Call 911 for a seizure lasting more than _______minutes. (Please Note: Depending on circumstances, NEDSRA staff may disregard this request and call 911 immediately.)

2.

3.

VNS Device Check box: If checked, parent/guardian must train staff on use of VNS device.

Parent/Guardian Signature:_____________________________________ Date: ___________________

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

FRONT OFFICE USE ONLY	***Date***	***Staff Name***
Noted in Registration System		
Scanned to PPT File		
Copy to Recreation Coordinator		
Hard copy filed		