



PARTICIPANT SEIZURE INFORMATION FORM



Participant _____ Date _____

Neurologist/Physician _____ Phone _____

Parks & Recreation Department

Adapted Programs

620 Laguna Street

Santa Barbara, CA 93101

(805) 564-5421

The registration information submitted for the above participant indicated the participant has seizures. We would appreciate your cooperation in answering the following questions to better understand if there are any medical needs. It is the responsibility of the participant or, for minors and dependent adults, their custodial parent or legal guardian to disclose all relevant information regarding the participant's health and special needs.

Participant Seizure History

	Date	Comments
Date of first seizure	/ /	
Date of most recent seizure	/ /	
Diagnosis and date	/ /	
Length of seizures		
Frequency of seizures		

	Yes	No	
Has had Status Epilepticus	<input type="checkbox"/>	<input type="checkbox"/>	
Has required emergency care for seizures.	<input type="checkbox"/>	<input type="checkbox"/>	
Has had an EEG. Describe test results.	<input type="checkbox"/>	<input type="checkbox"/>	
Has had an MRI. Describe test results.	<input type="checkbox"/>	<input type="checkbox"/>	
Does anything trigger a seizure?	<input type="checkbox"/>	<input type="checkbox"/>	
Has an aura.	<input type="checkbox"/>	<input type="checkbox"/>	
Periods of increased seizure activity.	<input type="checkbox"/>	<input type="checkbox"/>	
Likes to swim.	<input type="checkbox"/>	<input type="checkbox"/>	

Generalized Tonic-Clonic			
Aura or cry	<input type="checkbox"/>	<input type="checkbox"/>	
Loss of consciousness	<input type="checkbox"/>	<input type="checkbox"/>	
Stiffening	<input type="checkbox"/>	<input type="checkbox"/>	
Limbs jerking	<input type="checkbox"/>	<input type="checkbox"/>	
Irregular breathing	<input type="checkbox"/>	<input type="checkbox"/>	
Loss or bladder/bowel control	<input type="checkbox"/>	<input type="checkbox"/>	
Other	<input type="checkbox"/>	<input type="checkbox"/>	

Partial Epileptic Seizure			
Mental Confusion	<input type="checkbox"/>	<input type="checkbox"/>	
Aimless movements: chewing, walking, mumbling, picking at clothes, etc.	<input type="checkbox"/>	<input type="checkbox"/>	
Other	<input type="checkbox"/>	<input type="checkbox"/>	

Non-Convulsive Seizure			
Brief staring	<input type="checkbox"/>	<input type="checkbox"/>	
Tuning out	<input type="checkbox"/>	<input type="checkbox"/>	
Tic like movement	<input type="checkbox"/>	<input type="checkbox"/>	
Head movement or dropping	<input type="checkbox"/>	<input type="checkbox"/>	
Other	<input type="checkbox"/>	<input type="checkbox"/>	

Medication Name	Dosage	Times	Comments

Signature of participant OR, for minors and dependent adults, the custodial parent or legal guardian:

✓ Signature _____ Print Full Name _____ Date _____