# PARTICIPANT SEIZURE INFORMATION FORM

CITY OF SANTA BARBARA Parks & Recreation *Enriching People's Lives*

**Parks & Recreation Department**
Adapted Programs
620 Laguna Street
Santa Barbara, CA 93101
(805) 564-5421

Participant _____ Date_____

Neurologist\Physician _____ Phone_____

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 | Yes | No | 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 | | ❑ | ❑ | |
| Has required emergency care for seizures. | | ❑ | ❑ | |
| Has had an EEG. Describe test results. | | ❑ | ❑ | |
| Has had an MRI. Describe test results. | | ❑ | ❑ | |
| Does anything trigger a seizure? | | ❑ | ❑ | |
| Has an aura. | | ❑ | ❑ | |
| Periods of increased seizure activity. | | ❑ | ❑ | |
| Likes to swim. | | ❑ | ❑ | |
| **Generalized Tonic-Clonic** | | ❑ | ❑ | |
| Aura or cry | | ❑ | ❑ | |
| Loss of consciousness | | ❑ | ❑ | |
| Stiffening | | ❑ | ❑ | |
| Limbs jerking | | ❑ | ❑ | |
| Irregular breathing | | ❑ | ❑ | |
| Loss or bladder/bowel control | | ❑ | ❑ | |
| Other | | ❑ | ❑ | |
| **Partial Epileptic Seizure** | | ❑ | ❑ | |
| Mental Confusion | | ❑ | ❑ | |
| Aimless movements: chewing, walking, mumbling, picking at clothes, etc. | | ❑ | ❑ | |
| Other | | ❑ | ❑ | |
| **Non-Convulsive Seizure** | | ❑ | ❑ | |
| Brief staring | | ❑ | ❑ | |
| Tuning out | | ❑ | ❑ | |
| Tic like movement | | ❑ | ❑ | |
| Head movement or dropping | | ❑ | ❑ | |
| Other | | ❑ | ❑ | |

| 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** _____