



**School Health Program**

**Student Checklist: Seizure Disorder**

**Student Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**School Nurse:** \_\_\_\_\_ **Date:** \_\_\_\_\_

The student has demonstrated understanding and competency consistently to:

<b>SKILLS</b>	<b>YES</b>	<b>NO</b>	<b>COMMENTS</b>
Identify triggers for seizure			
State the name of the medication			
State the purpose for the medication			
State knowledge of medication: A. Side effects B. Adverse reactions C. Proper storage			
States need to call 911			
States the signs of precipitating seizure (Aura)			

The student agrees to follow the safety precautions with medication compliancy and to report any precipitating factors whenever possible.

**Student Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Parent Name/Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

I hereby acknowledge that the student listed above has demonstrated all the above listed skills.

**School Nurse Signature:** \_\_\_\_\_ **Date** \_\_\_\_\_

**Review Dates:** \_\_\_\_\_