BY YOUR SIDE™
Autism Therapy Services

Seizure Information Sheet

Child's Name: _____

Does your child have a history of seizures? ____ **Yes** _____**No**

If yes, please fill out the information below in detail:

Seizure Type:	**Describe what the seizure looks like:**
Average length of time the seizure lasts:	
How often seizures typically occur:	
Reaction to the seizure:	
Average length of time until return to regular activities:	
The Last seizure occurred on:	
Seizure triggers or warning signs:	
Special Considerations and Precautions:	
Planned strategies to support needs and safety issues when a seizure occurs:	
Medication Taken to Control Seizures (note name and amount given): _____ _____ _____ **Diastat?** ☐Yes☐No If **Yes**, please describe administration: _____ _____ **Vagus Nerve Stimulator**? ☐Yes☐No If **Yes**, describe magnet use: _____ _____ **Call 911** if: the seizure lasts more than _____ minutes	

Parent/Guardian Signature: _____ Date: _____

What actions would you like us to take if we observe what appears to be an allergic reaction?

_____
_____
_____
_____

Action for Minor Reaction:

1. If Symptoms are:
   _____
2. Administer (medication/dose/route):
   _____
3. Then call Parent/Guardian

Action for Severe Reaction:

1. If Symptoms are:
   _____
2. Administer (medication/dose/route):_____
3. Call 911
4. Then call Parent/Guardian

Does your child require the use of an EpiPen in the event of a severe allergic reaction?
_____ **Yes** _____ **No**

If yes, do you authorize BY YOUR SIDE-Autism Therapy Services staff to administer or attempt to administer to your child, or allow your child to self administer the lawfully prescribed Epipen?
_____**Yes** _____**No**

(Important Note: In the event that we administer an EpiPen to your child, we will first administer the EpiPen, then call 911, and then call you as quickly as possible)

Parent/Guardian Signature: _____ Date: _____/_____/_____

Printed Name: _____