ALHAMBRA SCHOOL DISTRICT
SEIZURE INTAKE FORM

Date:	School of Attendance:

STUDENT INFORMATION

Student Name:		Student ID#:	Date of Birth:	Age:
Gender: ☐ Male ☐ Female	Grade:	Homeroom Teacher:		
		Bus Driver:		
		Bus Number:		

PARENT/LEGAL GUARDIAN INFORMATION

Parent/Legal Guardian Name:			
Street Address:	City:	State:	Zip Code:
Telephone:	Fax #:		
Email Address:			
Parent/Legal Guardian Comments:			

HEALTH CARE PROVIDER: (Physician, Physician Assistant, Nurse Practitioner)

Name (Pediatrician/Physician):			
Street Address:	City:	State:	Zip Code:
Telephone:	Fax #:		
Email Address:			
Name (Neurologist/Physician; if applicable):			
Street Address:	City:	State:	Zip Code:
Telephone:	Fax #:		
Email Address:			
Date Diagnosed with Seizures:			
Type of Seizure:			
Receiving Treatment: ☐ Yes ☐ No	Type of Medication (including diastat, ketogenic diet, VNS):		
When was his/her last seizure (frequency):	Duration:		
Possible Side Effects:			
Known triggers (illness, flashing light, noise, etc.):			
Likelihood and Frequency of Seizures During School Hours:			
Please list student limitations/restrictions:			

______________________________________	____________________
Physician Signature	*Date*

Form No. 222/Rev. 7/16

EMERGENCY PLAN
For School:
During Transport:
Bus Garage:

COPY OF EMERGENCY PLAN RECEIVED	
____	____________________
Parent/Guardian Signature	***Date***
____	____________________
School Nurse (Health Assistant) Signature	***Date***
____	____________________
Teacher Signature	***Date***
____	____________________
Bus Driver Signature	***Date***
____	____________________
Physician Signature	***Date***