NISRA
Northern Illinois Special Recreation Association

Office Use Only:

Date Reviewed: _____
Initial: _____

Seizure Questionnaire

Revised: 4-15-2024

Please complete this form if the participant experiences seizures. **Please update this form whenever there is a change in the seizure information/plan and prompty submit it to NISRA.** NISRA requests that you review this form once a year and provide any necessary updates unless you have opted out due to no seizure activity within 5 years. ***Please see below.****

Participant's Name: _____

Completed By: _____ **Relationship:** _____ **Date:** _____

Medication(s):
Participant medication needs are to be noted on their ***Annual Information Update*** form which is distributed each year in the seasonal brochures. If the participant's medication needs have changed since submission of their *Annual Information Update* form, please submit a new update as soon as possible.

A ***Medication Permission*** form must be submitted if you are requesting NISRA staff to assist with the dispensing of scheduled oral or topical maintenance medication. To obtain a copy of the Annual Information Update form or Medication Permission form, please contact the NISRA office or download a copy of the forms from the NISRA website at www.nisra.org and click on the "Dates & Forms" tab.

☐ *Please check box and sign below if participant has not experienced a seizure in the last 5 years and you are not requesting accommodations regarding seizure care from NISRA staff (beyond basic first aid), in which case you can opt-out of providing an updated Seizure Questionnaire at this time.

Please note: NISRA staff will not administer rectal Diastat or perform any other invasive medical procedures.

1. Please describe a typical seizure: _____

   _____

   _____

2. Are there any symptoms prior to the onset of the seizure? (i.e. smells, stomach pain, fear, sounds, etc.) _____

   _____

3. What was the date of the participant's last seizure? _____/_____/_____ 4. How long does the typical seizure last? _____

Types of Seizure(s): *Please check all that apply.*

_____ Absence (staring spell) _____ Atonic (Drop) _____ Simple Partial

_____ Complex Partial _____ Generalized (Grand Mal) _____ Other (Explain): _____

Seizure Response Plan

In the event of a perceived seizure, **NISRA staff will follow basic first-aid procedures for the care of seizures.** Please list any additional actions you would like NISRA staff to take in the event of a seizure.

1. Call 911 for a seizure lasting more than _____ minutes. (Please note: depending on circumstances, NISRA staff may disregard this request and instead call 911 immediately)
2.
3.

☐ **VNS Device Check Box:** If checked, parent/guardian must train staff on use of VNS device.

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

Please return this completed form along with your Registration Form to the NISRA Office.