JOHNSON COUNTY KANSAS
Community Developmental Disabilities Organization

Daily Seizure Activity

Consumer Name: _____

The above listed person has seizure activity EVERY day. It is important to remember that the seizure(s) must be epileptic in nature and not medication induced or caused by another medical condition such as: high blood pressure, high fever, etc.

The type of seizure(s) experienced by this person are as follows: (Check All That Apply)

_____ Simple Partial Motor Signs

_____ Simple Partial Sensory Signs

_____ Complex Partial (Loss of Awareness)

_____ Generalized Absence (Petit Mal)

_____ Generalized Tonic Clonic (Grand Mal)

I certify that by signing this form that the data listed above is true and accurate.

Physician Signature / Title: _____

Printed Name: _____

Date of Signature: ____ / ____ / ____

Form Expires One Year From The Date of Signature.

REV. 6-12-18 gl

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