

QUESTIONNAIRE FOR A PARENT OF A STUDENT WITH SEIZURES



Please complete all questions. This information is essential for the school nurse and school staff in determining your student's special needs and providing a positive and supportive learning environment. If you have any questions about how to complete this form, please contact your child's school nurse.

CONTACT INFORMATION

Student's Name	School Year	Date of Birth	
School	Grade	Classroom	
Parent/Guardian	Phone	Work	Cell
Parent/Guardian Email			
Other Emergency Contact	Phone	Work	Cell
Child's Neurologist	Phone	Location	
Child's Primary Care Doctor	Phone	Location	
Significant medical history or conditions			

SEIZURE INFORMATION

1. When was your child diagnosed with seizures or epilepsy? _____

2. Seizure type(s):

Seizure Type	Length	Frequency	Description

3. What might trigger a seizure in your child? _____

4. Are there any warnings and/or behavior changes before the seizure occurs? YES NO

If YES, please explain: _____

5. How often does your child have a seizure? _____

6. When was your child's last seizure? _____

7. Has there been any recent change in your child's seizure patterns? YES NO

If YES, please explain: _____

8. How does your child react after a seizure is over? _____

9. How do other illnesses affect your child's seizure control? _____

BASIC FIRST AID: CARE AND COMFORT

10. What basic first aid procedures should be taken when your child has a seizure in school? _____

11. Will your child need to leave the classroom after a seizure? YES NO
If YES, what process would you recommend for returning your child to classroom (if applicable)

Basic Seizure First Aid

- ✓ Stay calm & track time
- ✓ Keep child safe
- ✓ Do not restrain
- ✓ Do not put anything in mouth
- ✓ Stay with child until fully conscious
- ✓ Record seizure in log

For tonic-clonic (grand mal) seizure:

- ✓ Protect head
- ✓ Keep airway open/watch breathing
- ✓ Turn child on side

SEIZURE EMERGENCIES**A Seizure is generally considered an Emergency when:**

- ✓ A convulsive (tonic-clonic) seizure lasts longer than 5 minutes
- ✓ Student has repeated seizures without regaining consciousness
- ✓ Student has a first time seizure
- ✓ Student is injured or diabetic
- ✓ Student has breathing difficulties
- ✓ Student has a seizure in water

12. Please describe what constitutes an emergency for your child? (Answer may require consultation with treating physician and school nurse.) _____

13. Has child ever been hospitalized for continuous seizures? YES NO
 If YES, please explain: _____

SEIZURE MEDICATION AND TREATMENT INFORMATION

14. What medication(s) does your child take?

Medication	Date Started	Dosage	Frequency and Time of Day Taken	Possible Side Effects

15. What emergency/rescue medications are prescribed for your child?

Medication	Dosage	Administration Instructions (timing* & method**)	What To Do After Administration:

* After 2nd or 3rd seizure, for cluster of seizure, etc.

** Orally, under tongue, rectally, etc.

16. What medication(s) will your child need to take during school hours? _____

17. Should any of these medications be administered in a special way? YES NO

If YES, please explain: _____

18. Should any particular reaction be watched for? YES NO

19. What should be done when your child misses a dose? _____

20. Should the school have backup medication available to give your child for missed dose? YES NO

21. Do you wish to be called before backup medication is given for a missed dose? _____

22. Does your child have a Vagus Nerve Stimulator? YES NO

If YES, please describe instructions for appropriate magnet use:: _____

SPECIAL CONSIDERATION AND PRECAUTIONS

23. Check all that apply and describe any considerations or precautions that should be taken:

- | | |
|---|--|
| <input type="checkbox"/> General health _____ | <input type="checkbox"/> Physical education (gym/sports) _____ |
| <input type="checkbox"/> Physical functioning _____ | <input type="checkbox"/> Recess _____ |
| <input type="checkbox"/> Learning _____ | <input type="checkbox"/> Field trips _____ |
| <input type="checkbox"/> Behavior _____ | <input type="checkbox"/> Bus transportation _____ |
| <input type="checkbox"/> Mood/coping _____ | <input type="checkbox"/> Other _____ |

GENERAL COMMUNICATION ISSUES

24. What is the best way for us to communicate with you about your child's seizure(s)? _____

25. Can this information be shared with classroom teacher(s) and other appropriate school personnel? YES NO

Parent's Signature: _____ Date: _____

Dates _____
 Updated _____