School Health Services
Questionnaire for Parent of a Student with Seizures

Dear Parent/Guardian:

According to the health information you provided, your child has had a history of seizures. Please complete the following information to assist the school nurse in developing an individualized seizure plan for your child. If you would like to discuss the plan, please contact the school nurse.

Student Name:_____DOB:_____Grade:_____

Contact Information

Parent/Guardian:_____

Phone: (h)_____(w)_____(c)_____

Parent/Guardian:_____

Phone: (h)_____(w)_____(c)_____

Physician/Healthcare Provider: _____Phone:_____

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 seizures for your child?_____
4. Are there warning and/or behavior changes before the seizure occurs? _____Yes_____No
5. When was your child's last seizure?_____
6. Has there been a recent change in your child's seizure patterns?_____
7. How does your child react after a seizure is over?_____
8. How do other illnesses affect your child's seizure control?_____
   _____
9. Will your child need to leave the classroom after a seizure? _____Yes_____No
   _____
10. Has your child ever been hospitalized for continuous seizures?_____Yes_____No
    _____

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Name of Student_____Grade_____

Seizure Medication and Treatment Information

11. What routine seizure medication(s) does your child take?

Medication	Date Started	Dosage	Frequency & time of Day Take	Possible Side Effects

12. What emergency/rescue medications(s) are prescribed for your child?

Medication	Dosage	Administration Instructions (timing* & method**)

**After 2nd or 3rd seizure, for cluster of seizure, etc. **Orally, under tongue, rectally, etc.*

13. What medication(s) will your child need to take during school hours? _____
14. Should any of these medications be administered in a special way? _____Yes _____No
    If YES, please explain:_____
15. Should any particular reaction be watched for? _____Yes _____No
    If YES, please explain: _____
16. Does your child have a Vagus Nerve Stimulator? _____Yes _____No
    If YES, please explain:_____

SPECIAL CONSIDERATIONS & PRECAUTIONS

Check all that apply and describe any consideration or precautions that should be taken:

*General Health*_____
*Physical functioning*_____
*Learning*_____
*Behavior*_____
*Mood/coping*_____
*Physical Education (gym/sports)*_____
*Recess*_____
*Field Trips*_____
*Bus Transportation*_____
*Other*_____

SIGNATURES

Parent/Guardian Signature:_____ Date:_____
Physician Name: _____ Phone:_____
Physician Signature:_____ Date:_____