

Post Falls School District #273

School Nursing Services

206 W. Mullan Ave, Post Falls ID 83854

PO Box 40, Post Falls, ID 83877

(208) 773-6976



Seizure Information

Dear Parent/Guardian:

If your child has seizures please complete this form and return it to your child's school.

Student's Name: _____

School: _____ Grade: _____ Teacher: _____

Parent/Guardian: _____ Phone: _____

Physician's Name: _____ Phone: _____

1. When was your child diagnosed with seizures? _____

2. When did last seizure occur? _____

Type(s) of Seizure	Frequency	Typical Duration

3. Some children have predictable behavior before and after seizures.

Behavior before seizures	Behavior and actions after seizure

4. Does your child take medication for seizures? Yes No Not Currently

Please list all medications prescribed, supplements or over the counter:

Medications	Dose/Time	Side Effects:

If your child needs medication at school, please bring the medication to the school office in the original container (an extra prescription bottle may be prepared for school at the pharmacy).

An Authorization for Medication Administration form will need to be completed.

5. If the school nurse has more questions regarding this form what is your preferred method of contact?

Phone or Email: _____

Parent/Guardian's signature: _____ Date: _____

Thank you,

Elizabeth Costin, BSN, RN

Post Falls School District Lead Nurse

Revised: June 2020