Carroll County Public Schools
Seizure-Parent Health Questionnaire

Student Name: _____ Date: _____

Date of Birth: _____ Grade: _____

You have indicated on the Emergency Procedure Card and/or health forms that your child has a history of seizures. Please complete the following questionnaire and return to your school nurse as soon as possible.

1. Date of last seizure:_____ Usual frequency of seizure:_____

   Date of last hospitalization for seizure:_____

2. Does your child have any known triggers to their seizures?_____

3. What warning signs does your child experience prior to a seizure? *Circle all that apply*

   Headache Odor Sight Disturbance
   Hearing Disturbance None Other:

4. What happens during a seizure? *Circle all that apply*

Mental State:	Confused Unconscious Dreamlike/Vacant/Staring Unchanged Other:
Loss of Control:	Bowel Bladder Other:
Breathing:	Normal Noisy Interrupted Other:
Muscle Tone:	Falls Down Rigid (whole body) Rigid (specific part of the body):_____ Decreased Tone Spasms/Tremors (Shaking) Other:
Movement:	Jerking (whole body) Jerking (specific part of the body): _____ Wandering Purposeful Movement
Eyes:	Change in Eyes Explain:
Other:	Slurred Speech Head Drops Vomiting Other:

5. How long does the seizure usually last? _____

6. What typically happens after the seizure? *Circle all that apply*

Irritable	Confused	Stomachache	Headache	Drowsy	Deep Sleep	Normal

7. Are medications needed to control the seizures? Yes / No If yes, please list below:

Medication Name	Amount Taken	Time of Day	Comments

Please advise the School Nurse immediately of changes in dose and/or type of medication.

Please note: Medication will only be given following CCPS Medication Procedures. The information you supply will be handled in a confidential manner to be used by the school nurse to guide care if an emergency arises. If clarification is required beyond this form, the nurse will contact the parent/guardian and/or the child's health care provider. If you have questions, please call the school nurse.

Parent/Guardian Signature:_____ Date: _____

Received by School Nurse: Nurse Signature: _____ Review Date: _____