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:
<table>
<thead>
<tr>
<th>Medication Name</th>
<th>Amount Taken</th>
<th>Time of Day</th>
<th>Comments</th>
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</tbody>
</table>

   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: __________________ Date: ______________