Bethel SCHOOLS

DAWN FOX
Nurse Administrator

Dear Parents,

According to our records, your child has seizures. It would be helpful to have updated information about your child's seizures so we can plan for the care of your child at school. Enclosed is a "**Questionnaire for Parents of Students with Seizures**" requesting updated information about your child. Please complete it and return it to the health room before the start of the next school year.

If your child needs to take medication during school hours or at school sponsored events next year, please have your health care provider complete the **Authorization of Oral Medication at School** and complete the parent section of the form. Being the completed medical and parent authorization form with the medication in a properly labeled container when school begins in the fall. Also, it would be a good idea to have three-day supply of seizure medication at school in case of a disaster. This would also require doctor's authorization.

Sincerely,

Dawn Fox, MS, RN, NCSN

Bethel SCHOOLS

AUTHORIZATION FOR ADMINISTRATION OF ORAL MEDICATION AT SCHOOL

Student Name: _____ Birth Date: _____

School: _____ Grade: _____

THIS PORTION TO BE COMPLETED BY THE PHYSICIAN/DENTIST

Diagnosis: _____

Name of Medication	**Dosage**	**Methods of Administration**	**Time of Day to be Taken**

If given PRN, specify the length of time between doses.

Student is capable to self-administer medication: ☐ Yes ☐No

If a health professional and a student's parent request that a student be permitted to carry his or her own medication and/or be permitted to self-administer the medication, the principal may grant permission after consulting with the school nurse

Possible side effect of medication: _____

Emergency procedure in case of serious side effects: _____

I request and authorize that the above-named student be administered the above-identified oral medication in accordance with the instructions indicated above from _____ to _____ (do not exceed current school year) as there exists a valid health reason which makes administration of the medication advisable during school hours.

_____ _____
Physician/Dentist Signature Date

_____ _____
Physician/Dentist (Print or Type) Telephone Number

Please Note: If samples of medication are to be given, they must be labeled with the name of the student, dosage and time to be given.

THIS PORTION TO BE COMPLETED BY THE PARENT/GUARDIAN

I request/authorize the school to administer medication to the above identified student in accordance with the doctor's instructions for the period from _____ to _____ (not to exceed the current school year). I understand that every effort will be made by school staff to administer the medication in a timely manner.

Permission to self-administer medication: ☐ Yes ☐ No

_____ _____
Parent/Guardian Signature Date

_____ _____
Home Telephone Number Work Telephone Number

EPILEPSY FOUNDATION®

Questionnaire for Parent of Student with Seizures

Please complete all questions. This information is essential for the school nurse and school staff in determining your child'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. When was your child's last seizure? _____
6. Has there been any recent change in your child's seizure patterns? ❒ YES ❒ NO
   If YES, please explain: _____
7. How does your child react after a seizure is over? _____
8. How do other illnesses affect your child's seizure control? _____

Basic First Aid: Care & Comfort

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

10. 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:

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

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

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

A seizure is generally considered an emergency when:

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

Seizure Medication and Treatment Information

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

Medication	Date Started	Dosage	Frequency and time of day taken	Possible Side Effects

14. 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.*

15. What medication(s) will your child need to take during school hours? _____
16. Should any of these medications be administered in a special way? ☐ YES ☐ NO
    If YES, please explain: _____
17. Should any particular reaction be watched for? ☐ YES ☐ NO
    If YES, please explain: _____
18. What should be done when your child misses a dose? _____
19. Should the school have backup medication available to give your child for missed dose? ☐ YES ☐ NO
20. Do you wish to be called before backup medication is given for a missed dose? ☐ YES ☐ NO
21. Does your child have a Vagus Nerve Stimulator? ☐ YES ☐ NO
    If YES, please describe instructions for appropriate magnet use:

Special Considerations & Precautions

22. 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 _____

General Communication Issues

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

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

Dates _____
Updated _____

Parent/Guardian Signature _____ **Date** _____