**STUDENT INTERVIEW FORM**

Student's Name _____ Age _____ Grade _____

School _____ Classroom _____

1. What kind of seizure(s) do you have? _____

2. How old were you when your seizures began? _____

3. Do you have any special feeling when a seizure is about to occur? _____

If so, can you describe the feeling? _____

_____

4. What do you think happens to you during a seizure? _____

_____

5. What do you think is happening inside your brain when you have a seizure? _____

_____

6. Describe how you usually feel after a seizure: _____

_____

_____

7. What medication(s) do you take?

| Medication | Dosage | Schedule |
|---|---|---|
| | | |
| | | |
| | | |

8. Who is responsible for your medications when you're at home?

_____

If student is responsible, then ask:
Do you remember on your own? _____

Does someone need to remind you or actually give them to you? _____

9. Do you do anything special to help you remember to take your medication? _____

10. What do you do if you miss your dose? _____

_____

11. Do you feel any different if you miss your dose? _____

_____

12. What things (if any) make it more likely you will have a seizure? (list) _____

_____

13. How often do you have seizures? _____

14. When do they occur most often? _____

_____

15. When was your last seizure? _____

_____

16. How do you feel before you have a seizure? _____

_____

17. Besides taking medication, how do you control your epilepsy? _____

_____

18. What special problems (if any) do you have in school that you feel are related to your epilepsy (e.g., grades, gym classes, recess, sports, teasing, etc.)? _____

_____

19. Have you told any of your friends about your seizures? (If so, when did you tell them? What have you told them? How did they react?) _____

_____

_____

20. Have you told any of your teachers you have seizures? (If so, when did you tell them? What have you told them? How did they react?) _____

_____

_____

21. What have your parents told you about epilepsy? _____

_____

How do they usually react when you have a seizure? _____

_____

22. What do your brothers and sisters know about your seizures? _____

_____

What do they do when you have a seizure? _____

_____

23. If you were to have a seizure in school, what would you like the following people to do for you?

Nurse _____

_____

Teacher _____

_____

Classmates _____

_____

Date Completed _____

Date Updated _____

School Nurse's Observations/Comments/Actions/Suggested

_____

_____

_____

_____

_____

_____

_____

**TEACHER'S INFORMATION SHEET**

Student's Name _____ Date Completed _____

**This student is being treated for a seizure disorder. The information below should assist you if a seizure occurs during class.**

Seizure type _____

Description of the seizure _____

_____

Possible triggers _____

Average length of time it lasts _____

Average length of time until student can return to regular activities _____

Possible warning and/or behavior changes prior to the seizure _____

_____

Average frequency _____

Usual time of day seizure occurs _____

Student's reaction to the seizure _____

_____

First aid you should provide _____

_____

**The student is receiving the following treatment to control the seizure(s):**

Name of medication _____ Name of medication _____

_____ _____

Amount and time given _____ Amount and time given _____

_____ _____

Possible side effects _____ Possible side effects _____

_____ _____

Other areas needing your attention _____

_____

_____

I have attached some additional information regarding this student's seizure type and treatment. If you have any questions, please do not hesitate to ask me. I am available from _____ to _____ on the following days _____

Otherwise, you can reach me at _____

School Nurse: _____

## TEACHER'S ANECDOTAL RECORD*

Student's Name _____ Date of Report _____

Teacher's Name _____

Time of observation: _____

Description of seizure or behavior: _____

Activities immediately preceding seizure:

Student's behavior after seizure: _____

How long did it last? _____

Were there any injures? ? yes ? no

If yes, describe: _____

Procedures followed by teacher/observer:

## REPORT OF MEDICATION SIDE EFFECTS

Check any side effects you have observed and add relevant details:

| | | | |
|---|---|---|---|
| ? Drowsiness | ? Slurred speech | ? Irritability | ? Nausea |
| ? Confusion | ? Unsteady walk | ? Inattention | ? Poor memory |

* Adapted with permission from Program Actions for Children with Epilepsy (PACE), 1983.