Forest Lake Area Schools
Health Services - Nursing

Seizure Student Questionnaire

School Year: ______________

Student Name: ____ Birthdate: ______________________

School Attending: ____ Grade: _______________________

Parent/Legal Guardian:______________________________ Relationship to Student: ________________

Home Phone: __________________ Work: ____________________ Cell: ________________________

Parent/Legal Guardian:______________________________ Relationship to Student: _______________

Home Phone: __________________ Work: ____________________ Cell: ________________________

Primary Physician: ______________________ Clinic: __________________ Phone: ________________

Neurologist: ___________________________ Clinic: __________________ Phone: ________________

1. When was your child diagnosed with seizures or epilepsy? __________________________________
2. What type of seizure was your child diagnosed with? _____________________________________
    a. What is the typical length of the seizures? ____
    b. How frequently do seizures occur? ____
    c. Description of your child's seizures: ____
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. How does your child reach after a seizure is over? ______________________________________
7. How do other illnesses affect your child's seizure control? __________________________________
8. 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 class: ___________________

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

   ____

Complete Back Side

10. Has your child ever been hospitalized or needed an ambulance for a seizure? ☐ Yes ☐ No
   If YES, please explain: ____
11. Does your child take any medications for seizure occurrence or prevention? ☐ Yes ☐ No
   If YES, what medications?: ____
12. Will your child need to have the emergency medications kept at school? ☐ Yes ☐ No
   If YES, please call the appropriate health office.
13. Does your child have a Vagus Nerve Stimulator? ☐ Yes ☐ No
   If YES, please provide instructions for appropriate magnet use: ______________________
14. Please list any other information we should be aware of to care for your child with seizures/epilepsy at school: ____

Parent/Legal Guardian Signature: ______________________ Date: ____________

Please Note:

- **Basic Seizure First Aid** will be done for all **OBSERVED** seizures unless otherwise indicated on the seizure plan/orders from the student's neurologist/physician.
- If we do **NOT** have a seizure plan/orders from the student's neurologist/physician, we will call **911** at the time of seizure.
- If a seizure lasts greater than **5 minutes**, we will call **911** unless otherwise indicated on the seizure plan/orders from the student's neurologist/physician.
- Emergency seizure medications will **NOT** be sent on field trips, unless otherwise indicated in physician orders or by the Licensed School Nurse. Therefore, 911 will be called if a seizure occurs while your child is off school grounds.

- If your child has a history of seizures/epilepsy, we request that you make accommodations with the health office regarding your child's emergency medications & signed authorizations.
- Please fill out and submit an *Authorization for Administration of Medication at School* form and physicians seizure orders/action plan to the appropriate health office
- If the parent/legal guardian and provider/prescriber feel the student can self-carry their emergency medication, please also fill out and submit a *Self-Carry/Self-Administration Medication Authorization Form* to the health office.