



Wausau School District Seizure Parent Questionnaire

Student Name _____ Date of birth _____ Grade _____
 Parent/Guardian _____
 Home Phone _____ Work _____ Cell _____
 Primary Health Care Provider _____ Phone _____
 Neurologist _____ Phone _____

SEIZURE INFORMATION

1. When was your child diagnosed with seizures or epilepsy? _____

2.

<i>Seizure Type</i>	<i>Length</i>	<i>Frequency</i>	<i>Description</i>

3. What might trigger a seizure in your child? _____

4. Are there any warnings and/or behavior changes before the seizure occurs? Y/ N If yes, explain:

5. When was your child's most recent seizure? _____

6. Has there been any recent change in your child's seizure patterns? Y/ N If yes, explain:

7. How does your child react after a seizure is over? _____

8. How do other illnesses affect your child's seizure control? _____

9. In addition to basic seizures first aid, what comfort measures should be taken if your child has a seizure at school? _____

10. Will your child need to go home after a seizure? Y/N If s/he may remain in school, what process do you recommend for returning your child to the classroom? _____

SEIZURE EMERGENCIES

11. Describe what is a seizure emergency for your child. _____

12. Has your child ever been hospitalized for continuous seizures? Y/N If yes, explain: _____

MEDICATIONS AND TREATMENT

13. What medications does your child take?

Medication	Dosage	Time	Possible side effects

14. What medications will your child need to take at school? _____

15. What emergency /rescued medications are prescribed for your child?

Medication	Dosage	Administration Instructions (timing* and method**)

* After 2nd or 3rd seizure, for cluster of seizure, etc. ** Orally, under tongue, rectally, etc.

17. Should any particular reaction be watched for? Y/N If yes, explain: _____

SPECIAL CONSIDERATIONS & PRECAUTIONS

18. Check and describe any precautions that should be taken.

- | | |
|---|--|
| <input type="checkbox"/> General health _____ | <input type="checkbox"/> Physical education/sports _____ |
| <input type="checkbox"/> Physical functioning _____ | <input type="checkbox"/> Recess _____ |
| <input type="checkbox"/> Learning _____ | <input type="checkbox"/> Field trips _____ |
| <input type="checkbox"/> Behavior _____ | <input type="checkbox"/> Bus transportation _____ |
| <input type="checkbox"/> Mood/coping _____ | <input type="checkbox"/> Other _____ |

Parent/Guardian Signature _____ Date _____

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