SEIZURE QUESTIONNAIRE FOR PARENT/GUARDIAN

Student's Name _____ School Year _____/_____

School _____ Teacher/ Homeroom _____

You have indicated on your student's enrollment forms, emergency card and/or health history that your student has a history of seizures. Please complete this questionnaire to share details with the school.

1. Has a doctor diagnosed your student with a seizure disorder? ❑ Yes -or- ❑ No
   If yes, what type of seizure: _____
   When was the first seizure: _____
2. Was your student's seizure caused by a high fever only? ❑ Yes -or- ❑ No
   If **Yes**, how often does this happen? _____
3. Has your student had a seizure in the last 12 months? ❑ Yes -or- ❑ No
   When was the last seizure: _____
4. When your student has a seizure, which of the following occurs?

   ❑ Generalized muscle contractions
   ❑ Loss of consciousness
   ❑ Brief muscular twitches
   ❑ Lack of attention/staring
   ❑ Seizures on one part/side of body only (specify): _____
   ❑ Tongue or cheek biting
   ❑ Urinary incontinence
   ❑ Nausea or vomiting
   ❑ Dilated pupils (eyes open or closed)
   ❑ Sudden tastes or smell
   ❑ Other, please describe: _____ _____
5. Does the seizure disorder prevent your student from participating in school activities?
   ❑ Yes -or- ❑ No
   If **Yes**, please select and describe any limitations needed below:
   ❑ Physical Ed / Gym (inside)
   ❑ Recess / Playground (outside)
   ❑ Sports
   ❑ Other: _____
   ❑ Field Trips
   ❑ Lunch
   ❑ Transportation / Buses
6. Is there anything else we need to know about your student's medical condition? *For example: any triggers, warning signs or behavior changes prior to seizure, usual time of day a seizure might occur, any other health issues/illnesses that may affect seizure control, etc.):*

   _____

   _____
7. Does your student need medication given to prevent or treat seizures at school? ❑ Yes -or- ❑ No

If your student needs medical attention or medication for a Seizure while at school, your student's medical provider must complete and sign a SEIZURE ACTION PLAN. Keep in mind that medications kept at school must have a pharmacy label and the details must match the student and the details on the Action Plan.

Parent/Guardian Signature _____ Date _____

Farmington PUBLIC SCHOOLS

SEIZURE ACTION PLAN

Attach child's photo

Student's Name _____

School Year _____/_____ Teacher/ Homeroom _____

School _____

Student has allergy to: _____

SEIZURE INFORMATION - *Please refer to the FPS SEIZURE QUESTIONNAIRE FOR PARENT/GUARDIAN for more info.*

Seizure Type	How Long it Lasts	How Often	What Happens

Epilepsy Surgery (type, date, side effects?)	**Care Needed after Seizure** (describe and when can they return to normal activity?)	
Device: ❑VNS ❑RNS ❑DBS Date Implanted:_____	**Diet Therapy:** ❑Ketogenic ❑Low Glycemic ❑Modified ❑Atkins ❑Other (describe) _____	**Triggers:**
Any Special Instructions for school:		

How to respond to a seizure (check all that apply)

- ☐ First aid – **Stay. Safe. Side.**
- ☐ Give rescue therapy according to SAP
- ☐ Notify emergency contact
- ☐ Notify emergency contact at _____
- ☐ Call 911 for transport to _____
- ☐ Other _____

First Aid for any seizure

- ☐ **STAY** calm, keep calm, begin timing seizure
- ☐ Keep me **SAFE** – remove harmful objects, don't restrain, protect head
- ☐ **SIDE** – turn on side if not awake, keep airway clear, don't put objects in mouth
- ☐ **STAY** until recovered from seizure
- ☐ Swipe magnet for VNS
- ☐ Write down what happens _____
- ☐ Other _____

When to call 911

- ☐ Seizure with loss of consciousness longer than 5 minutes, not responding to rescue med if available
- ☐ Repeated seizures longer than 10 minutes, no recovery between them, not responding to rescue med if available
- ☐ Difficulty breathing after seizure
- ☐ Serious injury occurs or suspected, seizure in water

When to call your provider first

- ☐ Change in seizure type, number or pattern
- ☐ Person does not return to usual behavior (i.e., confused for a long period)
- ☐ First time seizure that stops on its' own
- ☐ Other medical problems or pregnancy need to be checked

Student's Name _____ School Year _____/_____

EMERGENCY CONTACTS		
NAME	**PHONE NUMBER**	**RELATIONSHIP**

RESCUE MEDICATIONS - When rescue therapy may be needed and the details			
Situation - If Seizure (cluster, # or length)	**Name of Medication**	**How much to give (dose)**	**How to give (route)**

I am in agreement and authorize the medication/plan as stated in this two page plan (see page 1). I certify that this student requires such medication be given during school hours and that no alternative schedule is medically advisable.

Medical Provider Signature_____Date_____

Print Provider Name_____Phone_____

Address_____City/State_____Zip Code_____

Parent/Guardian Signature_____Date_____

Any additional Information to provide to First Responders from Parent/Guardian or Medical Provider:

NOTE: This form also serves as the FPS Authorization for Medication Plan for Allergies.