



Wausau School District Seizure Questionnaire

Student name: _____ Date of birth: _____

Parent/guardian: _____ Date: _____

Primary 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? No Yes

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? No Yes

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 seizure first aid, what comfort measures should be taken if your child has a seizure at school? _____

SEIZURE EMERGENCIES

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

12. Has your child ever been hospitalized for continuous seizures? No Yes

If yes, explain: _____

MEDICATIONS AND TREATMENT

13. What medications does your child take at home for seizures?

<i>Medication</i>	<i>Dosage</i>	<i>Time</i>	<i>Possible side effects</i>

15. Is your child prescribed an emergency or rescue medication? No Yes

Please add any additional information that would be helpful for school personnel to know about your child's seizure condition:

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