

CHAMBERSBURG AREA SCHOOL DISTRICT
SCHOOL HEALTH SERVICES
Epilepsy Questionnaire

Student's Name_____ School Year_____

School_____ Grade_____

Mother's Name_____ Phone(Home)_____ (Work)_____

Father's Name_____ Phone(Home)_____ (Work)_____

1. How long has your child had seizures?_____

2. What medication(s) does your child take?

Medication

Dosage

Frequency and Time of Day Taken

3. What happens when your child misses a dose?_____

4. Check any special considerations related to your child while at school and describe below.

____ Educational Concerns ____ Physical Ed. Precautions ____ Behavioral Concerns

____ Field Trip Considerations ____ Sports Precautions ____ Special Transportation

____ Emotional Concerns ____ Recess Precautions ____ Other

5. How often does your child see the doctor regarding seizures?

6. When was his/her last appointment?_____

7. The physician treating your child's seizures: Dr._____

Address_____ Phone_____

8. Does the school need any special information about your child's seizures?

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9. Seizure type_____

Describe what happens during seizure_____

What causes seizure?_____

How long does it last?_____

Are there any warnings and/or behavior changes before the seizure? ____Yes ____No Describe

Average Frequency_____

Usual Time of day_____

Date of last seizure_____

What reaction would we expect to see following a seizure?_____

Epilepsy Questionnaire

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