



Health Services Department

Seizure Health History
Parent Questionnaire

Student Name: _____ Grade: _____ School Year: _____

Parent/Guardian Name: _____ Contact Number: _____

Neurologist: _____ Contact Number: _____

Primary Physician: _____ Contact Number: _____

Significant Medical History or Conditions: _____

Seizure Information

When was your child diagnosed with seizures or epilepsy? _____

Table with 4 columns: Seizure Type, Average Length, Frequency, Description. It contains four empty rows for data entry.

What might trigger a seizure in your child? _____

Are there any warnings and/or behavior changes before the seizure occurs? [] YES [] NO

If YES, please explain: _____

How often does your child have a seizure? ___ x a day ___ x a month Other: _____

When was your child's last seizure? _____

In the past year, have there been any changes in your child's seizure patterns? [] YES [] NO

If YES, please explain: _____

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

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

Special considerations & Precautions

List and describe any consideration or precautions that may need to be considered.

Updated March, 2026

<p>Basic Seizure First Aid: Stay calm & track time Keep the child safe Do not restrain Do not put anything in your mouth Stay with the child until fully conscious Record seizure For tonic-clonic seizure: Protect head Keep the airway open/watch breathing Turn the child on its side</p>	<p>A seizure is generally considered an emergency when: Convulsive (tonic-clonic) seizure lasts longer than 5 minutes Student has repeated seizures without regaining consciousness Student is injured or has diabetes Student has breathing difficulties Student has a seizure in water</p>
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Basic First Aid: Care & Comfort

What basic first aid procedure should be taken when your child has a seizure at school?

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?

Medication and Treatment Information

What medication(s) does your child take?

Daily Medication	Dosage	Frequency & Time of Day Taken	Possible Side Effects

What emergency/rescue medications are prescribed to your child?

Emergency/Rescue Medication	Dosage	What to Do After Administration

Does your child have a Vagus Nerve Stimulator? YES NO

Parent Signature: _____ Date: _____