FORSYTH COUNTY SCHOOLS

Seizure Parent Questionnaire

(To be completed by a parent or guardian)

Student's Name: _____ Date of Birth: _____ FCS Student Number: _____

SEIZURE INFORMATION:

1. What type of seizure disorder or epilepsy has your child been diagnosed with?_____
2. When was your child diagnosed?_____
3. Please list any other medical conditions, diagnoses, development concerns, or health issues that may affect your child's seizure or care at school:
   _____
   _____
4. Date of your child's last seizure? _____
5. Is your child aware of their seizure condition and able to recognize or report symptoms/warnings? ☐YES ☐NO
6. Have you identified any specific seizure triggers (Example: illness, stress, lack of sleep, flashing lights, missed medication doses, heat etc.)? ☐YES ☐NO
   If YES, please describe:_____
7. Does your child show warning signs or behavior changes *before* a seizure? ☐YES ☐NO
   If YES, please describe:_____
8. Has there been any recent changes in seizure frequency, length, severity or type? ☐YES ☐NO
   If YES, please describe:_____
9. Has your child ever experienced status epilepticus (prolonged seizure emergency)? ☐YES ☐NO
   If YES, please explain: _____
10. Has child ever been hospitalized due to seizures or seizure-related complications? ☐ YES ☐ NO
    If YES, please explain: _____
11. When was the last time your child received their rescue/emergency medication? _____
12. How has your child responded to the medication? _____
13. How many times within the past 12 months has your child required their emergency seizure medication? _____
14. Has there been any recent change in your child's seizure patterns? ☐ YES ☐NO
    If YES, please explain:_____
15. What symptoms or behaviors does your child typically experience *after* a seizure (confusion, sleepiness, headache, aggression/irritability, weakness, etc.)?_____

SEIZURE MEDICATION AND TREATMENT INFORMATION

16. Please list all daily medications your child currently takes, including medications administered at home.

Medication Name	Dosage	Time and Frequency Administered	Possible Side Effects/Concerns

_____

Parent Name (PRINT)

_____ _____

Parent Signature Date