

STUDENT HEALTH HISTORY- SEIZURE

Student Name: _____		Student Number: _____	
Date of Birth: _____	School: _____	Teacher/Grade: _____	
Doctor: _____	Doctor's Number: _____	Ride Bus: Yes__ No__	

Allergies: _____

Parent/Guardian: _____ Home Phone: _____ Other Phone: _____

Parent/Guardian: _____ Home Phone: _____ Other Phone: _____

Emergency Contact: _____ Home Phone: _____ Other Phone: _____

Relationship: _____

Emergency Contact: _____ Home Phone: _____ Other Phone: _____

Relationship: _____

Year diagnosed with seizures: _____ Date of most recent seizure: _____

1.	What type of seizures (what are they called) does your child experience? _____
2.	What happens when your child has a seizure? _____
3.	How often do seizures occur? _____
4.	How long do the seizures usually last? _____
5.	Any recent hospitalizations? Date(s) _____ Reason(s): _____

	Yes	No
Has a seizure ever lasted more than 5 minutes? <i>If yes, what treatment was needed?</i>		
Has Emergency Medication ever been prescribed for your child? <i>If yes to above question, has it ever been given?</i>		
Does your child lose bowel or bladder control during a seizure? (circle which one)		
Has your child ever turned blue or stopped breathing during a seizure? <i>If yes, what treatment was needed?</i>		
Does anything seem to trigger a seizure? ☐ Flashing lights ☐ Video games ☐ Computers ☐ Other _____		
Are there any limitations to your child's activities? <i>If yes, please be specific and attach a health care provider's order for these limitations.</i>		

Comments or additional information: _____



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Does your child take any seizure medications at home? ____ Yes ____ No If yes, please list:

Medication	Dose	How often
1.		
2.		

Administer the emergency medications listed below in the event of a seizure at school.
District Medication Authorization Forms must be completed and signed by parents and the prescribing physician and be on file at the school before any medications may be administered. Parent must bring medications to school.

Medication	Dose	Describe When to Use
1.		
2.		

EMERGENCY PLANS:

- In the event of a lockdown, medication kept in the clinic will not be available to your child. We encourage you to discuss a plan with your child’s physician and the school nurse. Please note any special instructions to be included as part of your child’s Emergency Action Plan below.

- In the event of an evacuation, emergency medications will be taken to the evacuation site, whenever possible.

I understand that my child's Emergency Action Plan will be shared with appropriate school staff that have a need to know about the health condition. I further understand that the school is not responsible for damage or loss of equipment utilized in providing medically prescribed treatments or procedures.

I give permission for my child's health care provider to be contacted for information regarding my child's medical condition. I have reviewed and agree with the information provided on this Health History form.

Parent/Guardian: _____
Signature Date

Reviewed by: _____
School Nurse Date

FOR SCHOOL NURSE USE ONLY
Notes: _____

