QUESTIONNAIRE FOR PARENT OF A STUDENT WITH SEIZURES

Please complete all questions. This information is essential for the school nurse and school staff in determining your student’s special needs and providing a positive and supportive learning environment. If you have any questions about how to complete this form, please contact your child’s school nurse.

CONTACT INFORMATION:

Student’s Name: __________________________  School Year: ______________  Date of Birth: __________

School: __________________________  Grade: ________  Classroom: __________

Parent/Guardian Name: __________________________  Tel. (H): ________  (W): ________  (C): ________

Other Emergency Contact: __________________________  Tel.: ________  Location: __________

Child’s Neurologist: __________________________  Tel.: ________  Location: __________

Child’s Primary Care Dr.: __________________________  Tel.: ________  Location: __________

Significant medical history or conditions:

SEIZURE INFORMATION:

1. When was your child diagnosed with seizures or epilepsy?

2. Seizure type(s):

<table>
<thead>
<tr>
<th>Seizure Type</th>
<th>Length</th>
<th>Frequency</th>
<th>Description</th>
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3. What might trigger a seizure in your child?

4. Are there any warnings and/or behavior changes before the seizure occurs? YES  NO
   If YES, please explain:

5. When was your child’s last seizure?

6. Has there been any recent change in your child’s seizure patterns? YES  NO
   If YES, please explain:

7. How does your child react after a seizure is over?

8. How do other illnesses affect your child’s seizure control?

BASIC FIRST AID: Care and Comfort Measures

9. What basic first aid procedures should be taken when your child has a seizure in school?

10. 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 classroom:

Basic Seizure First Aid:
- Stay calm & track time
- Keep child safe
- Do not restrain
- Do not put anything in mouth
- Stay with child until fully conscious
- Record seizure in log

For tonic-clonic (grand mal) seizure:
- Protect head
- Keep airway open/watch breathing
- Turn child on side
11. Please describe what constitutes an emergency for your child? (Answer may require consultation with treating physician and school nurse.)

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

12. Has child ever been hospitalized for continuous seizures? YES NO

If YES, please explain: __________________________________________________________________________

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

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<thead>
<tr>
<th>Medication</th>
<th>Date Started</th>
<th>Dosage</th>
<th>Frequency and time of day taken</th>
<th>Possible side effects</th>
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14. What emergency/rescue medications needed medications are prescribed for your child?

<table>
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<tr>
<th>Medication</th>
<th>Dosage</th>
<th>Administration Instructions (timing* &amp; method**)</th>
<th>What to do after administration:</th>
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* After 2nd or 3rd seizure, for cluster of seizure, etc. ** Orally, under tongue, rectally, etc.

15. What medication(s) will your child need to take during school hours?

If YES, please explain: __________________________________________________________________________

16. Should any of these medications be administered in a special way? YES NO

If YES, please explain: __________________________________________________________________________

17. Should any particular reaction be watched for? YES NO

If YES, please explain: __________________________________________________________________________

18. What should be done when your child misses a dose?

______________________________________________________________________________________________

19. Should the school have backup medication available to give your child for missed dose? YES NO

20. Do you wish to be called before backup medication is given for a missed dose?

21. Does your child have a Vagus Nerve Stimulator? YES NO

If YES, please describe instructions for appropriate magnet use: __________________________________________________________________________

22. Check all that apply and describe any considerations or precautions that should be taken

☐ General health

☐ Physical functioning

☐ Learning:

☐ Behavior:

☐ Mood/coping:

☐ Other:

23. What is the best way for us to communicate with you about your child’s seizure(s)?

______________________________________________________________________________________________

24. Can this information be shared with classroom teacher(s) and other appropriate school personnel? YES NO

Parent/Guardian Signature: ___________________________ Date: ___________ Dates Updated: ________.