



# 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 child'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	Phone	Work	Cell
Parent/Guardian Email			
Other Emergency Contact	Phone	Work	Cell
Child's Neurologist	Phone	Location	
Child's Primary Care Doctor	Phone	Location	
Significant Medical History or Conditions			

## Seizure Information

- When was your child diagnosed with seizures or epilepsy? \_\_\_\_\_
- Seizure type(s) \_\_\_\_\_

Seizure Type	Length	Frequency	Description

- 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: \_\_\_\_\_
- When was your child's last seizure? \_\_\_\_\_
- Has there been any recent change 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? \_\_\_\_\_

## Basic First Aid: Care & Comfort

- What basic first aid procedures should be taken when your child has a seizure in 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 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 seizure:**
- Protect head
  - Keep airway open/watch breathing
  - Turn child on side

## Seizure Emergencies

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: \_\_\_\_\_

### 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 a first-time seizure
- Student has breathing difficulties
- Student has a seizure in water

## Seizure Medication and Treatment Information

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

Medication	Date Started	Dosage	Frequency and Time of Day Taken	Possible Side Effects

14. What emergency/rescue medications are prescribed for your child? \_\_\_\_\_

Medication	Dosage	Administration Instructions (timing* & method**)	What to Do After Administration

\* After 2<sup>nd</sup> or 3<sup>rd</sup> seizure, for cluster of seizure, etc.

\*\* Orally, under tongue, rectally, etc.

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

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?  YES  NO

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

If YES, please describe instructions for appropriate magnet use: \_\_\_\_\_

## Special Considerations & Precautions

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

- |   |  |
|---|--|
| <input type="checkbox"/> General health _____       | <input type="checkbox"/> Physical education (gym/sports) _____ |
| <input type="checkbox"/> Physical functioning _____ | <input type="checkbox"/> Recess _____                          |
| <input type="checkbox"/> Learning _____             | <input type="checkbox"/> Field trips _____                     |
| <input type="checkbox"/> Behavior _____             | <input type="checkbox"/> Bus transportation _____              |
| <input type="checkbox"/> Mood/coping _____          | <input type="checkbox"/> Other _____                           |

## General Communication Issues

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

Dates \_\_\_\_\_

Updated \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_