

The following form will assist the school nurse and staff in determining any special needs for your child and the development of an individualized healthcare plan (IHP). This form is to be completed at initial IHP development and every 2 years thereafter. If you desire a conference with the school nurse, please call your child's school for an appointment.

1. Does your child have a diagnosis of seizures from a healthcare provider: ☐ No ☐ Yes

Managing physician: _____ Phone: _____

2. History of Current Status

- Are there triggers for your child's seizures? ☐ No ☐ Yes If yes, explain: _____
- What type of seizures does your child have? _____
- Please list all medications your child takes: _____
- Age of child when seizures first began: _____
- How often does your child have a seizure: _____
- Describe past seizures: _____
- Over time, are the seizures: ☐ Same ☐ Better ☐ Worse

3. Symptoms

- What are the early signs and symptoms of your child's seizure? *(Be specific; include things the child might do.)* _____
- How does your child communicate his/her symptoms? _____
- How long do the seizures usually last: _____ seconds _____ minutes
- Please check the symptoms that your child has experienced in the past:

Skin	Mouth	Limbs	Throat/Face	Lungs	Heart
<input type="checkbox"/> Pale	<input type="checkbox"/> Twitching	<input type="checkbox"/> Jerking	<input type="checkbox"/> Choking	<input type="checkbox"/> Difficulty breathing	<input type="checkbox"/> Weak pulse
<input type="checkbox"/> Flushing	<input type="checkbox"/> Pulls to side	<input type="checkbox"/> Stiffening	<input type="checkbox"/> Staring	<input type="checkbox"/> Stops breathing	<input type="checkbox"/> Loss of consciousness
<input type="checkbox"/> Lips turn blue	<input type="checkbox"/> Drool	<input type="checkbox"/> Flailing	<input type="checkbox"/> Blank look		
		<input type="checkbox"/> Drop/no muscle tone	<input type="checkbox"/> Unresponsive to commands		

4. Treatment

- How have past seizures been treated? _____
- What was the child's response to treatment? _____
- Was there an emergency room visit? ☐ No ☐ Yes, explain: _____
- Was the child admitted to the hospital? ☐ No ☐ Yes, explain: _____
- What emergency treatment or medication has your healthcare provider recommended for use in a seizure? _____
- Has your healthcare provider provided you with a prescription for this medication? ☐ No ☐ Yes
- Have you ever used the emergency treatment or medication? ☐ No ☐ Yes
- Please describe any side effects or problems your child had in using the suggested treatment: _____

**Continued on reverse

5. Family/Home

- a. How do you feel that the whole family is coping with your child's seizure disorder? _____
- b. Do you or your child carry emergency medicine in the event of a seizure? ☐ No ☐ Yes
- c. Has your child ever needed the emergency medicine away from home? ☐ No ☐ Yes
- d. Do you feel that your child needs assistance in coping with his/her seizure disorder? ☐ No ☐ Yes

6. General Health

- a. How is your child's general health other than having a seizure disorder? _____
- b. Does your child have other health conditions? _____
- c. Has your child ever been hospitalized for any reason? _____
- d. Please add anything else you would like the school to know about your child's health: _____

7. Notes:

Parent/Guardian Signature: _____ **Date:** _____

Reviewed by: _____ **Date:** _____