



# 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. (H): \_\_\_\_\_ (W): \_\_\_\_\_ (C): \_\_\_\_\_  
 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):

| <i>Seizure Type</i> | <i>Length</i> | <i>Frequency</i> | <i>Description</i> |
|---------------------|---------------|------------------|--------------------|
|                     |               |                  |                    |
|                     |               |                  |                    |
|                     |               |                  |                    |
|                     |               |                  |                    |

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? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**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

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: \_\_\_\_\_

\_\_\_\_\_

**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:  
 ✓ A convulsive (tonic-clonic) seizure lasts longer than 5 minutes  
 ✓ Student has repeated seizures without regaining consciousness  
 ✓ Student has a first time seizure  
 ✓ Student is injured or diabetic  
 ✓ 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 needed 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?
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 considerations or precautions that should be taken

- General health \_\_\_\_\_
- Physical functioning \_\_\_\_\_
- Learning: \_\_\_\_\_
- Behavior: \_\_\_\_\_
- Mood/coping: \_\_\_\_\_
- Other: \_\_\_\_\_
- Physical education (gym)/sports: \_\_\_\_\_
- Recess: \_\_\_\_\_
- Field trips: \_\_\_\_\_
- Bus transportation: \_\_\_\_\_

**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

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Dates Updated: \_\_\_\_\_, \_\_\_\_\_