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

<table>
<thead>
<tr>
<th>Student’s Name</th>
<th>School Year</th>
<th>Date of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>School</td>
<td>Grade</td>
<td>Classroom</td>
</tr>
<tr>
<td>Parent/Guardian</td>
<td>Phone</td>
<td>Work Cell</td>
</tr>
<tr>
<td>Parent/Guardian Email</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Emergency Contact</td>
<td>Phone</td>
<td>Work Cell</td>
</tr>
<tr>
<td>Child’s Neurologist</td>
<td>Phone</td>
<td>Location</td>
</tr>
<tr>
<td>Child’s Primary Care Doctor</td>
<td>Phone</td>
<td>Location</td>
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</tbody>
</table>

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 & Comfort

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 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?

<table>
<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>
</tr>
</thead>
<tbody>
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</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dosage</th>
<th>Administration Instructions (timing* &amp; method**)</th>
<th>What to Do After Administration</th>
</tr>
</thead>
<tbody>
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</table>

* After 2nd or 3rd seizure, for cluster of seizures, 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:

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

Parent/Guardian Signature ___________________________ Date ______________

Dates _____________________ Updated _____________

DPC776
Seizure Action Plan

This student is being treated for a seizure disorder. The information below should assist you if a seizure occurs during school hours.

Student’s Name
Date of Birth

Parent/Guardian
Phone
Cell

Other Emergency Contact
Phone
Cell

Treating Physician
Phone

Significant Medical History

Seizure Information

<table>
<thead>
<tr>
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<th>Length</th>
<th>Frequency</th>
<th>Description</th>
</tr>
</thead>
</table>

Seizure triggers or warning signs: Student’s response after a seizure:

Basic First Aid: Care & Comfort
Please describe basic first aid procedures:

Does student need to leave the classroom after a seizure? ☐ Yes ☐ No
If YES, describe process for returning student to classroom:

Emergency Response
A “seizure emergency” for this student is defined as:

Seizure Emergency Protocol
(_check all that apply and clarify below)
☐ Contact school nurse at __________________________
☐ Call 911 for transport to __________________________
☐ Notify parent or emergency contact
☐ Administer emergency medications as indicated below
☐ Notify doctor
☐ Other __________________________

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Treatment Protocol During School Hours (include daily and emergency medications)

|-------------|------------|---------------------------|--------------------------------------------|

Does student have a Vagus Nerve Stimulator? ☐ Yes ☐ No
If YES, describe magnet use:

Special Considerations and Precautions (regarding school activities, sports, trips, etc.)
Describe any special considerations or precautions:

Physician Signature __________________________ Date __________________________

Parent/Guardian Signature __________________________ Date __________________________

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