

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

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

2. Seizure type(s)

Seizure Type	Length	Frequency	Description

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?

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 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? _____

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

Parent/Guardian Signature _____ Date _____

Dates _____
Updated _____



Pasco County Schools

Seizure Medical Management Plan

Student Name:	D.O.B:	School Year:
Diagnosis:		
Medication(s):		
Seizure Information		
Indicate type of seizure disorder _____ Tonic - Clonic _____ Myoclonic _____ Other _____ Simple Partial _____ Atonic _____ Complex Partial _____ Absence		
Seizure History		
Date of onset _____ Last Known Seizure _____ Seizure triggers: _____ TV/Video games _____ Computer monitor _____ Fire alarm/strobe light Aura (if known) _____		
Emergency Medication for Seizure		
Administer medication as directed below for seizures lasting more than _____ minutes.		
Medication: _____ Dose: _____ Route: _____ _____ If seizure continues after giving emergency medication, call 911. Special Instructions: _____		
List any Special Considerations or Precautions regarding sports, school activities and/or field trips: _____ _____		
Parent has provided emergency medication to school: <input type="checkbox"/> YES <input type="checkbox"/> NO		
<i>Print, type, or stamp Physician's Name & Information:</i> _____		
Address: _____ Phone: _____ Fax: _____		
Physician Signature: _____ Date: _____		
Parent Signature: _____ Date: _____		
School Nurse Signature: _____ Date: _____		
I hereby authorize the above named physician and Pasco County Schools staff to reciprocally release verbal, written, faxed, or electronic student health information regarding the above named child for the purpose of giving necessary medication or treatment while at school. I understand Pasco County Schools protects and secures the privacy of student health information as required by federal and state law and in all forms of records, including, but not limited to, those that are oral, written, faxed or electronic. I hereby authorize and direct that my child's medication or treatment be administered in the manner set forth in this medical management plan. I understand that all supplies are to be furnished/restocked by parent.		