

Seizure Information for School

Student Name: _____ Date of birth _____ Date _____

Parent/Guardian: _____ Phone _____ Cell/work _____

Health Care Provider treating Seizure: _____ Phone _____

How often does your Health Care Provider want to see your student for seizure check-up? _____

When did your student last see the Health Care Provider? _____

Do **you think** your student's seizures may be **life-threatening**? No Yes
(If YES, please see the school nurse as soon as possible)

Does your student's **health care provider think** the seizures may be **life-threatening**? No Yes
(If YES, please see the school nurse as soon as possible)

History and Current status

How old was your student when seizures began? _____

When was the last time your student had a seizure? _____

What type of seizure does your student have? (check all that apply)

Grand mal Absence or petit mal Other, explain:

Briefly describe what happens when your student has a seizure:

How long does the seizure last? _____ Seconds _____ Minutes _____ Hours

Describe what your student does immediately after seizures:

How often does your student have a seizure? (check one) Daily Weekly Monthly Yearly

Has there been a change in your student's seizure pattern? No Yes, explain:

Triggers

Are there any situations that may cause a seizure to occur? No Yes, explain:

Are there other illnesses that affect your student's seizures? No Yes, explain:

Is there a usual time of day seizures may occur? No Yes, explain:

Are there any signs or behavior changes before a seizure? No Yes, explain:

Treatment

What medications or treatments does your student use at school and at home? None

Meds _____

Treatments _____

Does your student have any difficulty with these medications—side effects, doesn't want to take them, etc?

No Yes, explain:

Does your student have any restrictions because of the seizures or the medication—activity restrictions or wears helmet? No Yes, explain:

Does your student understand the seizure condition and what he/she can do to manage them? No Yes

Does your student have a brother/sister/friend at school who understands the seizures? No Yes

Name of brother/sister/friend and grade in school _____

When your child has a seizure, what does he/she call the seizure?

Describe what you do at home when your student has a seizure:

How do you want the school to treat a seizure if it should occur at school?

Parent/Guardian signature _____ Date _____