QUESTIONNAIRE FOR PARENTS OF CHILD WITH EPILEPSY

Student's Name ____________________ School Year __________

School ____________________ Grade __________

The following information will be helpful to the school nurse and school staff in determining your child's special needs. Please complete all questions. A separate page is attached for adding more detailed information about your child's seizures.

1) How long has your child had seizures? ____________________

2) Is there a difference between past and current seizure patterns? If so, how have they changed? ____________________

3) How do other illnesses affect your child's seizure control? ____________________

4) What medication(s) does your child take?

Medication	Dosage	Frequency and Time of Day Taken

5) What medication(s) will your child need to take during school hours and when? ____________________

6) Should the medication be administered in a special way? ____________________

7) Should any particular reaction be watched for? ____________________

8) Does taking other medication(s) affect your child's seizure control? ____________________

9) What happens when your child misses a dose? ____________________

   What do you do when your child misses a dose? ____________________

   Should the school have backup medication available to give your child for a missed dose? ____________________

10) How should the school handle a missed dose? ____________________

11) Check any special considerations related to your child's epilepsy while at school, and describe them briefly.

   □ Educational concerns □ Physical education precautions □ Special considerations for field trips

   □ Behavioral concerns □ Sport precautions □ Special transportation to and from school

   □ Emotional concerns □ Recess precautions □ Other

   Please briefly describe any concerns ____________________

12) What is the best way for us to communicate about your child's health condition? ____________________

13) How often does your child see the doctor regarding seizures? ____________________

   When was his/her last appointment? ____________________

14) The physician treating your child's seizure is: Name ____________________

   Address ____________________ Phone __________

15) Does the school have permission to contact your child's physician? ____________________

16) Does your child have other recurring or chronic health problems? ____________________

17) Can this information be shared with the classroom teacher(s), student's peers, bus driver, and other appropriate school personnel?

____

Action Plan for *SEIZURES*

Student's Name ____Date _______________

You have noted on the Student Health Profile that your child has seizures. It is important to have current health information and direction in the event s/he needs assistance at school. Please complete this form and return to the school nurse as soon as possible. If you have any questions, please call the school nurse at your child's school. Thank you!

Conditions that have triggered a seizure in your child: (check all that apply)

____ bright or flashing lights
____ noise
____ excitement
____ emotional stress
____ fatigue
____ hunger/low blood sugar
____ no triggers identified
____ other ____

Symptoms noted:

____ blank expression
____ lip smacking
____ eye twitching
____ tremors
____ repetitive movement
____ eyes roll back
____ loss of consciousness
____ drooling
____ vocalization
____ body stiffens
____ breathing stops
____ incontinent
____ other ____

What type seizure has been diagnosed?
___ grand mal (tonic-clonic) ____ petit mal (absence) ___ other ______________________________________
How often do seizures occure?____
Date of last seizure? ______________________________ How long did it last? ___________________________
Child's response to seizure: ____
Has child been hospitalized within the past year as a result of seizures? ____ no ____ yes – date ______________
Seizures are currently being treated by Dr. ____________________________________ phone # ________________

Medications taken to control seizures:

	Medication	Dose	Route	Time
1.	________________________	____________	_________________	________________________
2.	________________________	____________	_________________	________________________
3.	________________________	____________	_________________	________________________
4.				

If medication is needed, has it been brought to school? ____ no ____ yes

The usual treatment at school for a student having a seizure is::

1. ***Provide for student' safety and privacy.***
2. ***Assess breathing; begin CPR and have someone call 911 if absent.***
3. ***Record symptoms noted prior, during, and after event.***
4. ***Notify parent.***
5. ***Other:*** ____

Parent signature: ____Day phone # _______________