

Seizure Questionnaire

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

Child's Name _____ ID# _____ Grade/School Year _____

Parent/Guardian _____ Home Phone Number _____

Work Number _____ Cell Phone/Pager Number _____

Where does your child receive his/her seizure care (name of clinic) _____

Name of Physician or Health Care Provider _____ Clinic Phone Number _____

Seizure Information

1. When was your child diagnosed with seizures? _____

2. Seizure type (s):

Seizure type	Length	Frequency	Description

3. What might trigger a seizure in your child? _____

4. Are there any warning 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. Has your child ever been hospitalized for seizures? ☐ Yes ☐ No

If Yes, please explain: _____

8. Does he/she have a Vagus Nerve Stimulator (VNS)? ☐ Yes ☐ No. Where is the magnet worn? _____

Describe use of the magnet. _____

Signs of Seizures

Please check behaviors that apply to your child

- | | | |
|---|--|---|
| <input type="checkbox"/> lip smacking | <input type="checkbox"/> falling down | <input type="checkbox"/> blue color to lips |
| <input type="checkbox"/> behavioral outbursts | <input type="checkbox"/> rigidity/stiffness | <input type="checkbox"/> froth from mouth |
| <input type="checkbox"/> staring | <input type="checkbox"/> thrashing/jerking | <input type="checkbox"/> gurgling/grunting noises |
| <input type="checkbox"/> twitching | <input type="checkbox"/> loss of bowel/bladder control | <input type="checkbox"/> loss of consciousness |
| <input type="checkbox"/> sudden cry or squeal | <input type="checkbox"/> shallow breathing | |
| <input type="checkbox"/> other _____ | | |

Possible Behaviors After Seizure

Please check behaviors that apply to your child

- | | | |
|--|--|--|
| <input type="checkbox"/> tiredness | <input type="checkbox"/> weakness | <input type="checkbox"/> sleeping, difficult to arouse |
| <input type="checkbox"/> somewhat confused | <input type="checkbox"/> regular breathing | <input type="checkbox"/> other _____ |

How long do these behaviors last? _____

Basic First Aid

Basic Seizure First Aid

- Stay calm & track time
- Call school nurse
- Do not restrain
- Do not put anything in mouth
- Stay with child until fully conscious
- Record seizure in log
- Protect head, keep child safe
- Keep airway open/watch breathing
- Turn child on side

9. What additional first aid procedures should be taken when your child has a seizure in school?

Seizure Medications

Medications taken at home

Medication name	How much?	When is it taken?

Medication orders for school

Medication name	How much?	When should it be taken?

10. Does your child have any side effects from these medications? _____

Seizure Emergencies

A Seizure is generally considered an EMERGENCY when:

- A convulsive seizure lasts longer than 5 minutes
- Student has repeated seizures without regaining consciousness
- Student has a first time seizure
- Student is injured or has diabetes
- Student has breathing difficulties
- Student has a seizure in water

11. Are there any other conditions that are emergencies for your child? _____

Special Considerations & Safety Precautions

Please check all that apply and describe any considerations or precautions that should be taken.

- | | |
|---|---------------------------------------|
| <input type="checkbox"/> Physical education _____ | <input type="checkbox"/> Recess _____ |
| <input type="checkbox"/> Field trips _____ | <input type="checkbox"/> Sports _____ |
| <input type="checkbox"/> Bus transportation _____ | <input type="checkbox"/> Other _____ |

Parent/Guardian Signature _____ Date _____