

## 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?

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### 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? \_\_\_\_\_

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### 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 \_\_\_\_\_