STUDENT WITH SEIZURES
Parent Questionnaire

Student's Name_____Grade_____ Homeroom_____
Parent's Name(s)_____Ph. (H)_____(W)_____
Name of Student's Doctor (for seizures)_____ Ph._____

The following information will help your child's school nurse and school personnel meet the health needs of your child while he/she is at school. Please answer the questions to the best of your ability. If you wish to personally discuss your child's seizures with the school nurse, you may reach the school nurse at:

Nurse's Name_____ Ph._____ Days_____

1. How long has your child had seizures?_____

2. How would you describe your child's seizures? _____
   _____
   _____

3. What is the frequency of your child's seizures? _____

4. When was the last time your child has a seizure? _____

5. Is there a difference between past and current seizure patterns? Yes _____ No _____
   If yes, how have they changed? _____
   _____
   _____

6. How so other illnesses affect your child's seizure control? _____
   _____
   _____

7. How often does your child see the doctor regarding seizures? _____
   When was his/her last appointment? _____

8. During the past year how many times has your child been treated in the ER or hospitalized for seizures?
   _____

9. What medication(s) does your child take to control seizures? (everyday and as needed).
   Name Dose Time Possible Side Effects
   _____
   _____
   _____
   _____

10. What medication(s) will your child need to take during school hours? _____
    _____
    _____

11. Should the medication be administered in a special way? _____
    _____

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12. What, if any, side effects does your child have from his/her medication(s)?
_____
_____

13. Does taking other medication(s) affect your child's seizure control? _____

14. How does your child react if he/she misses a dose of medication?_____
_____

15. What do you do when your child misses a dose of medication? _____
_____

16. Does your child need any special considerations related to his/her seizures while at school? (Check all that apply and describe briefly)

___ Educational Concerns_____
___ Behavioral Concerns _____
___ Emotional Concerns _____
___ Physical Education _____
___ Sports participation _____
___ Recess precautions _____
___ Special considerations on field trips _____
___ Observation for side effects from medications _____
___ Other _____

17. Does your child have any other recurring or chronic health problems? _____
_____

18. What is the best way to communicate with you about your child's seizure(s), medication(s), and other observations/concerns (e.g., calendars, diary, written notes, etc.)? _____
_____
_____

19. If your child has a seizure at school, what actions do you advise school personnel to take?
_____
_____
_____

20. Do you think your child hold him/herself back from participating in activities at school because of his/her seizures? Yes ____ No _____ If yes, please describe. _____
_____

21. Is there anything else you would like for school personnel to know about your child's seizures?
_____
_____
_____

May this information be shared with the classroom teacher(s), bus driver(s) and other appropriate school personnel? Yes _____ No _____

_____ _____
Signature of Parent/Guardian Completing Questionnaire Date