SEIZURE DISORDER QUESTIONNAIRE

WISCONSIN RAPIDS PUBLIC SCHOOLS

Student's Name: _____ Grade _____ School Year: _____

Parent(s)/Guardian: _____

Primary Health Care Provider: _____

Physician Treating Seizures: _____

Emergency Numbers			
Mother's Home Phone		Mother's Work Phone	
Father's Home Phone		Father's Work Phone	
Mother's Cell Phone		Physician's Phone	
Father's Cell Phone		Family/Friend Phone	

Please tell us what you want us to do in case of a seizure at school.

Check below all that apply	
IF MY CHILD'S SEIZURE INCLUDES:	DO THIS:
☐ **Absence** (petit mal) seizure, brief staring spell	☐ Do nothing ☐ Report to parents daily ☐ Report to parents weekly
☐ **Partial Seizure** may walk around, perform aimless activities _____ _____ _____	☐ Do not restrain ☐ Report to parent immediately ☐ Send note home to parent ☐ Allow _____ minutes to rest and re-orient self and then return to class ☐ Other _____
☐ **Convulsive Seizure:** ☐ Sudden cry, fall, rigidity, followed by muscle jerks, saliva on lips, bluish skin color ☐ Possible loss of bladder or bowel control ☐ Usually lasts ____ minutes ☐ Some confusion, headache and fatigue followed by full return to consciousness ☐ Other: _____ _____ _____ _____	☐ Notify parents immediately ☐ Notify parents by sending note home ☐ Follow general first aid guidelines: • Protect from nearly hazards • Place folded towel under head • Do not attempt to put anything in mouth or try to restrain in any way • Treat injuries that may have occurred • Allow ____ minutes to rest and re-orient self and return to class • If single seizures lasts more than ____ minutes call parents/911 • If multiple seizures occur call parents/911

Comments: _____

_____

Parent signature: _____ Date: _____

School Nurse signature: _____ Date of Review: _____

SEE OTHER SIDE

SEIZURE DISORDER

1. How long has your child had seizures? _____

2. How do other illnesses affect your child's seizure control? _____

3. Are there any warning and/or behavioral changes before the seizure? _____

4. How long does a seizure last? _____

5. How often does your child have seizures? _____

6. Date of last seizure? _____

7. Current Medications. _____

8. Will your child need to take medication during school hours? ☐ Yes ☐ No (If yes, you must have a *Parent Permission for Administering Over-The-Counter Medication* form signed by your child's doctor on file for this school year.)

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

   ☐ Educational concerns: _____

   ☐ Behavioral/Emotional concerns: _____

   ☐ Physical Education/Recess Precautions: _____

   ☐ Special transportation to and from school: _____

10. How often does your child see the doctor regarding seizures? _____

11. How often does your child have blood work completed? _____

12. What was the date of last doctor's appointment? _____

Any additional information: _____