**HEALTH SERVICES**
Coopersville Area Public Schools
# Seizure Health History Parent 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 the school nurse.

Student Name: _____ Date of Birth: ____/____/____ School Year: _____

School: _____ Grade: _____

| **Emergency Contact Information** | | Home: | Work: | Cell: |
|---|---|---|---|---|
| Parent/Guardian: | | | | |
| Parent/Guardian: | | | | |
| Other: | | | | |
| Neurologist: | | | | |
| Primary Doctor: | | | | |

## Seizure Information

When was your child diagnosed with seizures or epilepsy? _____

Seizure type(s)

| Seizure Type | Average Length | Frequency | Description |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

What might trigger a seizure in your child? _____

Are there any warnings and/or behavior changes before the seizure occurs? …….. ☐ YES ☐ NO

If YES, please explain: _____

How often does your child have a seizure? _____ x a day _____ x a month Other: _____

When was your child's last seizure? _____

In the past year, have there been any changes in your child's seizure patterns? …… ☐ YES ☐ NO

If YES, please explain: _____

How does your child react after a seizure is over? _____

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

## Basic First Aid: Care & Comfort Measures

The box at right shows standard first aid procedures that will be implemented in CAPS for a student having a seizure. Are there additional actions that should be taken when your child has a seizure in school? …… ☐ YES ☐ NO

If YES, please explain: _____

_____

_____

Will your child need to leave the classroom after a seizure? …..... ☐ YES ☐ NO

If YES, what process would you recommend for returning your child to the classroom?

_____

_____

**Basic Seizure First Aid:**
- ✓ Stay calm & track time
- ✓ Keep child safe
- ✓ Do not restrain
- ✓ Do not put anything in mouth
- ✓ Stay with child until fully conscious
- ✓ Record seizure in log

**For tonic-clonic seizure:**
- ✓ Protect head
- ✓ Keep airway open/watch breathing
- ✓ Turn child on side

Student Name: _____ Date of Birth: ____/____/____ School Year: _____

## Seizure Emergencies

The box at right lists seizure situations that are generally considered to be emergencies. Please describe what constitutes an emergency for your child. (Answer may require consultation with treating physician and school nurse.)

_____

_____

**A seizure is generally considered an emergency when:**

- Convulsive (tonic-clonic) seizure lasts longer than 5 minutes
- Student has repeated seizures without regaining consciousness
- Student is injured or has diabetes
- Student has a first-time seizure
- Student has breathing difficulties
- Student has a seizure in water

Has child ever been hospitalized for continuous seizures? …….. ☐ YES ☐ NO

If YES, please explain: _____

_____

_____

## Medication and Treatment Information

What medication(s) does your child take?

| MEDICATION | DOSAGE | FREQUENCY & TIME OF DAY TAKEN | POSSIBLE SIDE EFFECTS |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

What emergency/rescue medications are prescribed for your child?

| MEDICATION | DOSAGE | WHAT TO DO AFTER ADMINISTRATION: |
|---|---|---|
| | | |
| | | |
| | | |

Does your child have a Vagus Nerve Stimulator? …… ☐ YES ☐ NO

## Special Considerations & Precautions

Does your child wear a "medical alert" necklace/bracelet? ..... ☐ YES ☐ NO

Is your child participating in sports or school sponsored extra-curricular activities? ……. ☐ YES ☐ NO

If YES, please explain: _____

Is your child comfortable alerting others when experiencing symptoms of a possible seizure? …….. ☐ YES ☐ NO

What are your child's feelings about having a seizure disorder? _____

_____

_____

Check all that apply and describe any consideration or precautions that should be taken:

☐ General health: _____ ☐ Physical education: _____

☐ Physical functioning: _____ ☐ Recess: _____

☐ Learning: _____ ☐ Field trips: _____

☐ Behavior: _____ ☐ Bus Transportation: _____

☐ Mood/coping: _____ ☐ Other: _____

What is the best way for us to communicate with you about your child's seizure(s)? _____

Parent's Signature: _____ Date: _____