*PARENT TO COMPLETE BOTH PAGES AND SIGN AT THE BOTTOM OF PAGE 2*

EPILEPSY FOUNDATION®

# Questionnaire for Parent of a Student with Seizures

Please complete all questions. This information is essential for the school nurse and school staff in determining your child'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

Student's Name ______ School Year ______ Date of Birth ______

School ______ Grade ______ Classroom ______

*Parent/Guardian (REQUIRED)* ______ *Phone* ______ Work ______ Cell ______

*Parent/Guardian Email (REQUIRED)* ______

*Other Emergency Contact (REQUIRED)* ______ *Phone* ______ Work ______ Cell ______

Child's Neurologist ______ Phone ______ Location ______

Child's Primary Care Doctor ______ Phone ______ Location ______

Significant Medical History or Conditions ______

## Seizure Information

1. When was your child diagnosed with seizures or epilepsy? ______
2. Seizure type(s)

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

3. What might trigger a seizure in your child? ______
4. Are there any warnings 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. How does your child react after a seizure is over? ______
8. How do other illnesses affect your child's seizure control? ______

## Basic First Aid: Care & Comfort

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

10. 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 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

## Seizure Emergencies

11. Please describe what constitutes an emergency for your child? (Answer may require consultation with treating physician and school nurse.)

12. Has child ever been hospitalized for continuous seizures? ☐ YES ☐ NO
If YES, please explain:

**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

## Seizure Medication and Treatment Information

13. What medication(s) does your child take?

| Medication | Date Started | Dosage | Frequency and Time of Day Taken | Possible Side Effects |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

14. What emergency/rescue medications are prescribed for your child?

| Medication | Dosage | Administration Instructions (timing* & method**) | What to Do After Administration |
|---|---|---|---|
| | | | |
| | | | |

** After 2nd or 3rd seizure, for cluster of seizure, etc.* *** Orally, under tongue, rectally, etc.*

15. What medication(s) will your child need to take during school hours? ____________
16. Should any of these medications be administered in a special way? ☐ YES ☐ NO
If YES, please explain: ____________
17. Should any particular reaction be watched for? ☐ YES ☐ NO
If YES, please explain: ____________
18. What should be done when your child misses a dose? ____________
19. Should the school have backup medication available to give your child for missed dose? ☐ YES ☐ NO
20. Do you wish to be called before backup medication is given for a missed dose? ☐ YES ☐ NO
21. Does your child have a Vagus Nerve Stimulator? ☐ YES ☐ NO
If YES, please describe instructions for appropriate magnet use:

## Special Considerations & Precautions

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

☐ General health ____________ ☐ Physical education (gym/sports) ____________
☐ Physical functioning ____________ ☐ Recess ____________
☐ Learning ____________ ☐ Field trips ____________
☐ Behavior ____________ ☐ Bus transportation ____________
☐ Mood/coping ____________ ☐ Other ____________

## General Communication Issues

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

24. Can this information be shared with classroom teacher(s) and other appropriate school personnel? ☐ YES ☐ NO

Dates ____________
Updated ____________

Parent/Guardian Signature ____________ Date ____________

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*DOCTOR TO COMPLETE AND SIGN*

EPILEPSY FOUNDATION®

# Seizure Action Plan

Effective Date

This student is being treated for a seizure disorder. The information below should assist you if a seizure occurs during school hours.

Student's Name | Date of Birth

Parent/Guardian | Phone | Cell

Other Emergency Contact | Phone | Cell

Treating Physician | Phone

Significant Medical History

## Seizure Information

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

Seizure triggers or warning signs: | Student's response after a seizure:

## Basic First Aid: Care & Comfort

Please describe basic first aid procedures:

Does student need to leave the classroom after a seizure? ☐ Yes ☐ No

If YES, describe process for returning student to 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

## Emergency Response

A "seizure emergency" for this student is defined as:

Seizure Emergency Protocol
(Check all that apply and clarify below)

- ☐ Contact school nurse at ____________
- ☐ Call 911 for transport to ____________
- ☐ Notify parent or emergency contact
- ☐ Administer emergency medications as indicated below
- ☐ Notify doctor
- ☐ Other ____________

## 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

## Treatment Protocol During School Hours (include daily and emergency medications)

| Emerg. Med. ✓ | Medication | Dosage & Time of Day Given | Common Side Effects & Special Instructions |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Does student have a Vagus Nerve Stimulator? ☐ Yes ☐ No If YES, describe magnet use:

## Special Considerations and Precautions (regarding school activities, sports, trips, etc.)

Describe any special considerations or precautions:

Physician Signature ____________________ Date ____________

Parent/Guardian Signature ____________________ Date ____________

OPC772

# PHYSICIAN TO COMPLETE FOR EMERGENCY SEIZURE CONTROL MEDICATIONS

·PHYSICIAN'S REQUESTST FOR ADMINISTRATION OF MEDICATION TO STUDENT

Name of Student ________ Birth Date ________ ID Number ________

Address ________ Telephone Number ________ Zip Code ________

The above named student has ____________________
Name of Disease or Syndrome

I am requesting that the above named student be administered the following medication during school hours:

Name of Medication ________ Type of Medication, i.e: Tablet, Liquid, Inhaler ________

Dosage ________ Time to administer ________

Possible Side Effects :________________________

The phone nuumbe where I may be ·reached in the event of a reaction to the medication or an emergency is________________________

Physician's Name_____ _____ (Pleasa print ortyPe) . Hospital Affifiation ___________ _

Address ----------_---Telephone# ___________Fax#_____________

Physician's Sigr1a:ture ____________________ Date -------

*This request is valid for 1 year fro·m date of signature. Any change in medication or dose requires a new request form.

Rev. 11/04

**PARENT COMPLETES**

CHICAGO PUBLIC SCHOOLS

PARENT REQUEST FOR ADMINISTRATION OF MEDICATION TO A STUDENT

_______________________ _______________ _______________
Name of Student Birth Date ID Number

_______________________ _______________ _______________
Address Telephone Zip Code

I _______________________ (Mother, Father, Legal Guardian) of the above named student, give permission to the school nurse to administer medication as requested by my child's physician _______________________ during school hours.
NAME OF PHYSICIAN

I will bring the medication to school nurse or principal/designee in original container appropriately labeled by the pharmacist or licensed provider.

_______________________
Signature of Parent / Guardian

_______________________
Address

_______________________
City Zip

_______________________
Home Phone Business Phone

_______________ ****EMAIL(REQUIRED ):_______________________****
Date

*This request is valid for 1 year from date of signature. Any change in medication or dose requires a new request form.

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