Seizure Questionnaire and Update

Student: ___________________________ DOB: ____________________Valid for school year: ____________

Please complete this form for your students' seizure needs so staff can plan effectively for their care while at school. **Please note that if your student is participating in activities before and after the school day including after school care, extracurricular activities/trips, athletics, or camps, it is imperative that YOU inform the supervising adults of this student's medical needs.**

When was student diagnosed with seizures or epilepsy? _________________Last seizure: _____________

Seizure Type(s)	*Length*	*Frequency*	*Description*

Has hospitalization been needed in the past for continuous seizures? Yes _____ No _____ (when _____________)
What might trigger a seizure for this student? ____
Are there any warnings and/or behavior changes before a seizure occurs? Yes ____ No _____ (explain)
____
How does your student react after a seizure? ____
Does your student have a Vagus Nerve Stimulator? Yes ______ No _______

Daily Medication	*Amount Taken*	*How Often*

Does your student have emergency seizure medication? Yes _____ No_____ (If yes, see school for form)
Controlled substances such as diazepam and midazolam will be kept in a secure location at the school. Students are not allowed to self-carry or self-administer controlled substances.

As parent/ guardian of the above-named student, I understand that it is the responsibility of the parent/ guardian to notify the school of changes in health conditions. I give permission to share this information with staff on a need-to-know basis. I give consent to exchange medical information with the student's physician as needed.

Signature of Parent/Guardian: ____ Date: _________________

Print Name: ____Phone: ___________________

Neurologist's Name: ____Phone: __________________

School Nurse Signature: ____Date: __________________