QUESTIONNAIRE FOR PARENTS OF CHILD WITH EPILEPSY

Student's Name _____ School Year _____

School _____ Grade _____ Classroom _____

Mother's Name _____ Phone (home) _____ (work) _____

Father's Name _____ Phone (home) _____ (work) _____

The following information will be helpful to the school nurse and school staff in determining your child's special needs. Please complete all questions. A separate page is attached for adding more detailed information about your child's seizures.

Nurse's Name: _____ Phone: _____

1. How long has your child had seizures? _____

2. Is there a difference between past and current seizure patterns? If so, how have they changed? _____

_____

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

_____

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

Medication	Dosage	Frequency and Time of Day Taken

_____

_____

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

_____

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

_____

7. Should any particular reaction be watched for? _____

_____

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

_____

9. What happens when your child misses a dose? _____

_____

What do you do when your child misses a dose? _____

_____

Should the school have backup medication available to give your child for a missed dose? _____

Should the school have medication available to give your child in case it was not brought to school that day?

10. Do you wish to be called before backup medication is given for a missed dose? _____

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

- ? Educational concerns _____
- ? Behavioral concerns _____
- ? Emotional concerns _____
- ? Physical education precautions _____
- ? Sport precautions _____
- ? Recess precautions _____
- ? Special considerations for field trips _____
- ? Special transportation to and from school _____
- ? Other _____

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

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

When was his/her last appointment? _____

14. The physician treating your child's seizures is

Name _____

Address _____

_____ Phone Number _____

15. Does the school need any special information about your child's seizures? _____

_____

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

17. Can this information be shared with the classroom teacher(s), student's peers, bus driver, and other appropriate school personnel? _____

Parent's Signature _____

Date Completed _____

Updated _____

Updated _____

Student's Name _____ Date _____

SEIZURE TYPE I

Seizure type _____

Describe what happens during the seizure _____

_____

What triggers the seizure? _____

How long does it last? _____

How long should the student wait after the seizure before returning to the regular school schedule?

_____

Are there any warnings and/or behavior changes before the seizure? _____

Average frequency _____ ? daily ? weekly ? monthly ? yearly

Usual time of day seizure(s) occur _____

Date of last seizure _____

First aid if seizure(s) occur at school _____

Student's reaction to seizure(s) _____

_____

SEIZURE TYPE II

Seizure type _____

Describe what happens during the seizure _____

_____

What triggers a seizure? _____

How long does it last? _____

How long should the student wait after the seizure before returning to the regular school schedule?

_____

Are there any warnings and/or behavior changes before the seizure? _____

_____

Average frequency _____ ? daily ? weekly ? monthly ? yearly

Usual time of day seizure(s) occur _____

Date of last seizure _____

First aid if seizure(s) occur at school _____

Student's reaction to seizure(s) _____

_____