Student _____ Date of Birth _____ Grade _____

Seizure Questionnaire/Individual Health Plan

School Year_____

Please complete and return to the School Nurse. The following information is helpful in determining any special needs.

Person to contact:	Relationship:	Work Phone:	Home Phone:
1.			
2.			
3.			
4.			

Family Physician:	Clinic:	Phone:

Hospital:	Phone:	
		Health Insurance: _____Yes _____No

Child's age at diagnosis of seizures _____

How often does your child have seizures? _____

When was your child's last seizure? _____

Has your child ever been kept overnight in the hospital for seizures? YES NO Date: _____

List conditions which generally cause seizures:_____

Does your child have an aura (early warning sign) before the seizure? YES NO If YES, explain what the aura (early warning sign) is: _____

_____

Please describe a typical seizure: _____

_____

How long does the seizure usually last? _____

How long after the seizure before your child can return to regular activities?_____

CONTINUED . . .

Please list any medications your child is taking for seizures:

Name of Medication	Amount Taken	How Taken	How Often

Please list any side effects of your child's medications:_____

If a medication is to be given at school, a medication form must be completed yearly. The medication must be in original labeled container. (When you get the prescription filled, please ask the pharmacist to put it into two containers so your child will have one for school and one for home use.)

What action do you want school personnel to take, if your child does not respond to treatment/medication?

_____

Are there any classroom or physical education accommodations needed for your child?

_____

In an acute emergency the student will be transported by ambulance to the hospital. Transportation in a non-acute situation is the responsibility of the parent/guardian. Any charges incurred are the responsibility of the parent/guardian.

Hospital of choice:_____

Please add anything else you would like school personnel to know about your child's seizure disorder.

_____

First Aid for seizures:

- Protect the student from injury
- Cushion head.
- Help person to lying position, preferably on their side.
- Remove glasses.
- Loosen tight fitting clothing.
- Keep area clear of sharp or hard objects.
- Monitor length of seizure.
- Speak softly.
- Be reassuring and supportive when consciousness returns.
- DO NOT force any objects into the person's mouth.
- DO NOT restrain movements.
- DO NOT offer food or liquids until fully awake.
- Document what happened before, during and after the seizure; length of seizure; time seizure began; what parts of body were involved and how.
- Stay with student until full recovery has occurred. Allow the student to rest if they need it.
- Notify parent.

Emergency Plan:

911 will be called if:

- Seizure lasts longer than two minutes,
- Child is having difficulty breathing,
- Vomit is aspirated,
- An injury occurs during the seizure or
- status epilepticus occurs (child goes from one seizure right into another).

Nursing Diagnosis	Goal	Plan
1. Potential for injury.	Student will remain safe during a seizure.	◆School Nurse (SN) will instruct staff in strategies to protect child during seizure and other safety measures.
2. Potential for aspiration during a seizure.	Student will not aspirate during seizure.	◆Position child on his/her side if possible. Clear secretion if necessary. Provide instruction for staff.
3. Potential for medication non-compliance.	Student understands condition and complies with medication regimen.	◆Student will demonstrate age appropriate understanding of seizures and medications.
4. Potential for alteration in attention and behavior related to seizures and/or medication.	Student will experience success in educational setting.	◆SN will educate staff of potential learning deficits due to side effects of medication and seizures.

Plan initiated:

Date/Grade: _____ Signature: _____

Plan reviewed/updated:

Date/Grade: _____ Signature: _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Date: _____ Copy Given To: _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

School nurse may share this information with appropriate school personnel YES NO

I authorize reciprocal release of information related to seizure disorders between the school nurse and the health care provider.

_____

Parent/Guardian Signature Date