

**MOBERLY SCHOOL DISTRICT  
Health Services FY11 School Year**

**Seizure Health History**

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 your child's school nurse.

**CONTACT INFORMATION:**

Student's Name: \_\_\_\_\_ School Year: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 School: \_\_\_\_\_ Grade: \_\_\_\_\_ Classroom: \_\_\_\_\_  
 Parent/Guardian Name: \_\_\_\_\_ Tel. (H): \_\_\_\_\_ (W): \_\_\_\_\_ (C): \_\_\_\_\_  
 Other Emergency Contact: \_\_\_\_\_ Tel. (H): \_\_\_\_\_ (W): \_\_\_\_\_ (C): \_\_\_\_\_  
 Child's Neurologist: \_\_\_\_\_ Tel: \_\_\_\_\_ Location: \_\_\_\_\_  
 Child's Primary Care Dr.: \_\_\_\_\_ Tel: \_\_\_\_\_ Location: \_\_\_\_\_  
 Significant medical history or conditions: \_\_\_\_\_

**SEIZURE INFORMATION:**

1. When was your child diagnosed with seizures or epilepsy? \_\_\_\_\_

2. Seizure type(s):

<i>Seizure Type</i>	<i>Length</i>	<i>Frequency</i>	<i>Description</i>

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 and Comfort Measures**

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

<p><b>Basic Seizure First Aid:</b></p> <ul style="list-style-type: none"> <li>✓ Stay calm &amp; track time</li> <li>✓ Keep child safe</li> <li>✓ Do not restrain</li> <li>✓ Do not put anything in mouth</li> <li>✓ Stay with child until fully conscious</li> <li>✓ Record seizure in log</li> </ul> <p><u>For tonic-clonic (grand mal) seizure:</u></p> <ul style="list-style-type: none"> <li>✓ Protect head</li> <li>✓ Keep airway open/watch breathing</li> <li>✓ Turn child on side</li> </ul>
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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: \_\_\_\_\_  
 \_\_\_\_\_

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**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:

- ✓ A convulsive (tonic-clonic) seizure lasts longer than 5 minutes
- ✓ Student has repeated seizures without regaining consciousness
- ✓ Student has a first time seizure
- ✓ Student is injured or diabetic
- ✓ 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 needed medications are prescribed for your child?

Medication	Dosage	Administration Instructions (timing* & method**)	What to do after administration:

\* After 2<sup>nd</sup> or 3<sup>rd</sup> 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?

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 considerations or precautions that should be taken

- |   |   |
|---|---|
| <input type="checkbox"/> General health _____       | <input type="checkbox"/> Physical education (gym)/sports: _____ |
| <input type="checkbox"/> Physical functioning _____ | <input type="checkbox"/> Recess: _____                          |
| <input type="checkbox"/> Learning: _____            | <input type="checkbox"/> Field trips: _____                     |
| <input type="checkbox"/> Behavior: _____            | <input type="checkbox"/> Bus transportation: _____              |
| <input type="checkbox"/> 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

► **Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_