**BRADFORD COUNTY DISTRICT SCHOOLS and**
**BRADFORD COUNTY HEALTH DEPARTMENT**
**SCHOOL HEALTH SERVICES**

# SEIZURE DISORDER QUESTIONNAIRE/HISTORY

**(To be completed by Parent)**

**PLACE I.D. PHOTO HERE**

**Name: _____D.O.B. _____ School Yr. _____**

Parent: _____Primary Phone # _____

Physician _____ Phone _____

Year Diagnosed _____ Date of most recent seizure _____

List all medications your child takes: _____

_____

Does your child need medication during school hours? ☐ Yes ☐ No

Does student have a Vagal Nerve Stimulator? ☐ Yes ☐ No Does he/she carry a magnet? ☐ Yes ☐ No

Does student have Diastat? ☐ Yes ☐ No

Known trigger(s): _____

Does the student experience an aura before having a seizure? ☐ Yes ☐ No If yes, what kind do they have?

_____

Your child's signs of a seizure are (check all that apply):

☐ Staring ☐ Twitching/shaking of body part _____

☐ Picking at clothes ☐ Walking around the room ☐ Loss of bowel or bladder control

☐ Unconsciousness ☐ Full body rigidity then jerking ☐ Anger or behavioral problems

☐ Child turns blue or has breathing problems

☐ Other: Please describe: _____

How often do seizures occur? _____

How long do the seizures normally last? _____

Are there any limitations to your child's activities? ☐ Yes ☐ No If yes, please describe:

_____

_____

Does your child require any protective equipment (helmet, etc.)? ☐ Yes ☐ No If yes, please list and explain:

_____

_____

Other considerations that will assist the school in providing safe care for your child:

_____

**<u>If any seizure lasts longer than 5 minutes, Diastat is given or there are multiple seizures, it is district policy to call 9-1-1.</u>**

**Authorization for Health Care Provider and School Nurse to Share Information:**

I authorize my child's school nurse to assess my child as regards his/her special health care needs and to discuss these needs with my child's physician as needed throughout the school year. I understand this is for the purpose of generating a health care plan for my child. I understand I may withdraw this authorization at any time and that this authorization must be renewed annually.

Parent/ Guardian Signature _____Date _____

Notes _____

_____

Signature below indicates that the plan is reviewed and appropriate documentation is complete.

School Nurse Signature _____ Date_____

Rev. 4/10