School District of Springfield Township
Seizure Health History Form

Please complete all questions. This information is essential for the school nurse and school staff in determining your child'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	Grade
Parent/Guardian	Phone	Work	Cell
Parent/Guardian Email			
Other Emergency Contact	Phone	Work	Cell
Child's Neurologist	Phone	Location	
Child's Primary Care Doctor	Phone	Location	
Significant Medical History or Conditions			

Seizure Information

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

2. What type of seizures does your child have?

Simple Partial	☐	Absence (Staring Spells)	☐	Complex Partial (petit mal)	☐
Atonic (drop seizures)	☐	Tonic (stiffening seizures)	☐	Myoclonic (jerks)	☐
Generalized tonic-clonic (Grand Mal)	☐	Any other type_____			

3. Please describe a typical seizure, how long it lasts, and what procedure is followed for your child after the seizure.
_____
_____
_____

4. What might trigger a seizure in your child? _____
5. Are there any warnings and/or behavior changes before the seizure occurs? ☐ YES ☐ NO
   If YES, please explain: _____
6. When was your child's last seizure? _____
7. What is the longest your child has been seizure free?_____
8. Has there been any recent change in your child's seizure patterns? ☐ YES ☐ NO
   If YES, please explain: _____
9. How does your child react after a seizure is over? _____
10. How do other illness affect your child's seizure control?_____
11. What tests has your child had for their seizures (for example EEG, MRI, etc.) _____

Basic First Aid: Care & Comfort

12 What basic first aid procedures should be taken when your child has a seizure in school?

13. 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:

Basic Seizure First Aid

- Stay calm & track time
- Keep child safe
- Do not restrain
- Do not put anything in mouth
- Stay with child until fully conscious
- Record seizure in log

For tonic-clonic seizure:

- Protect head
- Keep airway open/watch breathing
- Turn child on side

Seizure Emergencies

14. Please describe what constitutes an emergency for your child? (Answer may require consultation with treating physician and school nurse.)

15. Has child ever been hospitalized for continuous seizures? ❒ YES ❒ NO

If YES, please explain:

Call 911 when_____

A seizure is generally considered an emergency when:

- Convulsive (tonic-clonic) seizure lasts longer than 5 minutes
- Student has repeated seizures without regaining consciousness
- Student is injured or has diabetes
- Student has a first-time seizure
- Student has breathing difficulties
- Student has a seizure in water

Seizure Medication and Treatment Information

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

Medication	Date Started	Dosage	Frequency and Time of Day Taken	Possible Side Effects

17. What emergency/rescue medications are prescribed for your child?

Medication	Dosage	Administration Instructions (timing* & method**)	What to Do After Administration

** After 2nd or 3rd seizure, for cluster of seizure, etc.* *** Orally, under tongue, rectally, etc.*

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

19. Should any of these medications be administered in a special way? ❒ YES ❒ NO

If YES, please explain: _____

20. Should any particular reaction be watched for? ❒ YES ❒ NO

If YES, please explain: _____

21. What should be done when your child misses a dose? _____

22. Should the school have backup medication available to give your child for missed dose? ❒ YES ❒ NO

23. Do you wish to be called before backup medication is given for a missed dose? ❒ YES ❒ NO

24. Does your child have a Vagus Nerve Stimulator? ❒ YES ❒ NO

If YES, please describe instructions for appropriate magnet use:

Special Considerations & Precautions

25. Check all that apply and describe any consideration or precautions that should be taken:

❒ General health _____
❒ Physical functioning _____
❒ Learning _____
❒ Behavior _____
❒ Mood/coping _____
❒ Physical education (gym/sports) _____
❒ Swimming _____
❒ Recess _____
❒ Field trips _____
❒ Bus transportation _____
❒ Other _____

Is there anything else you would like us to know to help assist your child at school:

_____

Thank you for providing this information to help us provide the best care we can for your child. This information and your child's picture may be shared with school personnel who work directly with your child and when deemed necessary for your child's educational experience.

Please sign and return this form to your child's school nurse.

Parent / Guardian Signature: _____ Date: _____

Reviewed by School Nurse: _____ Date: _____

Based on: Epilepsy Foundation of America (2008) Questionnaire for Parent of a Student with Seizures 1//2016