



Parent Seizure Information Form

To the parent of: _____ Grade: _____ Date: _____

In reviewing the *Student Health Inventory Form* you completed for your child, you indicated that he/she has been diagnosed with a seizure disorder/epilepsy. In order to provide better health services for your child in school, we are requesting that you complete and return this form to the school nurse. If you have any questions or concerns, please feel free to contact me. All medical information is confidential and will be shared only with school staff working directly with your child. Thank you.

This is no longer a health issue for my child. (Please sign and date this form.)

What type of seizures does your child have? _____

When did your child have his/her first seizure? _____

Was it related to a specific event or illness (e.g. high fever)? _____

Date of last seizure _____

How often do the seizures occur? _____

Is there an aura or warning sign just before the seizure? _____

Describe the seizure: _____

How long does the seizure last? _____

How does your child act after the seizure? _____

Are there any triggering or precipitating factors? _____

Is your child on any medication for the seizures? Yes No

Name of medication(s) _____ When is it taken? _____

Has there been a recent change in the pattern of the seizures? _____

Name of your child's licensed health care provider treating him/her for seizures? _____

Licensed health care provider's telephone number: _____ Date of last visit? _____

Do we have your permission to contact the above licensed health care provider if questions arise regarding your child's care at school? Yes No

Are there any special instructions for school personnel? _____

Signature of Parent/Guardian

Date

Filed in Clinic by: _____

Date: _____