

**Avenue City School**  
**SEIZURE HEALTH HISTORY**

Student's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ School Year \_\_\_\_\_

Teacher \_\_\_\_\_ Grade \_\_\_\_\_

Mother's Name \_\_\_\_\_ Phone: (H) \_\_\_\_\_ Phone: (W) \_\_\_\_\_

Father's Name \_\_\_\_\_ Phone: (H) \_\_\_\_\_ Phone: (W) \_\_\_\_\_

Name of Child's Doctor: (for seizures) \_\_\_\_\_ Phone: \_\_\_\_\_

The following information is helpful to your child's school nurse and school staff in determining any special needs for your child. Please answer the questions to the best of your ability. If you desire a conference with the school nurse, please call for an appointment.

Nurse's Name \_\_\_\_\_ Phone: (work) \_\_\_\_\_

1. How long has your child had seizures? \_\_\_\_\_

2. What type of seizure does your child have? \_\_\_\_\_

3. What may trigger the seizure? \_\_\_\_\_

4. How often does your child have a seizure? \_\_\_\_\_

5. Describe the seizure. \_\_\_\_\_

6. How long does the seizure last? \_\_\_\_\_

7. When was your child's last seizure? \_\_\_\_\_

8. Does your child know when he/she is going to have a seizure before if occurs? \_\_\_\_\_

9. Describe your child's behavior after a seizure. \_\_\_\_\_

10. Please list the medications your child takes for seizures (everyday and as needed). . .

	<i>Name of Medication</i>	<i>Dose</i>	<i>Frequency</i>
<i>In School</i>			
<i>At Home</i>			

If medications are to be given during school, a medication permission slip needs to be filled out yearly. Medications must be in the original labeled container. (When you have prescriptions filled you can ask the pharmacist to put them into two containers so you'll have one for school and one for home use).

11. What if any side effects does your child have from his/her medication? \_\_\_\_\_

12. How many times has your child been treated in the emergency room for seizures? \_\_\_\_\_

13. Does your child need any special considerations related to his/her seizures while at school? \_\_\_\_\_

14. Please describe briefly. \_\_\_\_\_

15. Have you ever attended seizure education classes? \_\_\_\_\_

16. Has your child ever attended seizure education classes? \_\_\_\_\_

**Thank you for your time and assistance in assessing your child's special needs in school.**