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BOARD OF EDUCATION: Andrew Cruz • Christina Gagnier • Irene Hernandez-Blair • James Na • Joe Schaffer • SUPERINTENDENT: Norm Enfield, Ed.D.

Seizure Disorder Health History/Update (Completed by Parent/Guardian)

To the Parent/Guardian of ____ Grade ______________
Home Room/Teacher ____________________________________School ______________________________

According to the school records, your child has a seizure disorder. The school needs the following information in order to assist your child in case of a seizure. Immediate care may be of an emergency nature. Please complete the following information and return it to the School Nurse.

1. At what age did the first seizure occur? ________ Was it following a high fever? Yes ________ No ______
2. Was it in connection with an illness? Yes________ No______ If yes, please explain _____________________
3. Approximate date of last seizure ____
4. How frequently **does** your child have seizures? □ Daily □ Other ______________________________________
5. Does the student experience an Aura? Yes _________ No ______ Describe Aura ________________________
6. Describe the triggers that may bring on seizures: □ Too much screen time □ Flashing lights □ Stress
   □ Exhaustion □ Other ____
7. Describe the seizure: □ General convulsions □ Repetitive movements □ Staring/blank gaze
   □ Change of skin color (pale, blue) □ Loss of consciousness/fall to ground □ Labored breathing
   □ Dilation of pupils □ Involuntary loss of urine or feces □ Other ______________________________________
8. Approximately how long does a seizure last? ____
9. Any recent change in seizure pattern? ____
10. Describe your child's behavior following the seizure ____
11. When was your child last seen by a physician for his/her seizure disorder? ____________________________
12. Does your student take daily meds at home for seizures? Yes No
13. Does your student ride the bus? Yes No
14. Does your student participate in before and/or afterschool activities? No _____ If yes, program? ________________

Date Began	Medication	Dosage	Freq/Time of Day	Route	Side Effects

15. Does your student have an emergency medication prescribed for seizures? Yes ____________ No ______
    If yes, when was it last administered? ____

****Please fill have your physician fill out the physician authorizations form for emergency seizure medication

Date Began	Medication	Dosage	Instructions (Timing/Route)	Action after Administration

16. Does your student have a VNS? Yes_________ No______. If yes, please have your physician fill out the physician authorization form for VNS.

***Please have your physician fill out the seizure action plan. If a seizure action plan is not submitted, basic seizure first aid will be provided, which may include calling 911 for any seizure activity.

Print Parent/Guardian Name __________________________Signature _____________________________
Contact Phone Number _______________________________ Date ________________________________

PLEASE RETURN THIS FORM TO THE SCHOOL NURSE