SEIZURE DISORDER ASSESSMENT FORM

HEALTH SERVICES
SCHOOL DISTRICT U-46

School Year:_____ Grade/Teacher:_____

Student Name:_____ID#:_____Birthdate:_____

Address: _____
House Number / Street Apt # if necessary City ZIP

PARENTS PLEASE COMPLETE THE FOLLOWING INFORMATION:

Parent/Guardian Name:_____
Home Phone: ( )_____
MomCell Phone ( )_____Mom Work phone ( )_____
Dad Cell Phone ( )_____Dad Work phone ( )_____
Primary Physician Name: _____
Medical Group_____ Phone: ( )_____
Specialty Physician Name: _____
Medical Group_____ Phone: ( )_____

STUDENT'S SEIZURE HISTORY:

Diagnosis: _____Age or year of diagnosis _____
Is your child still bothered by Seizures? ☐No ☐Yes
When was child's last doctor appointment regarding the seizure disorder? _____
When was the child's last seizure episode? _____

What do your child's seizures look like?_____

_____

Have the seizures changed from the past? ☐No ☐Yes If yes, how have they changed? _____
_____

What do you do if you see your child having a seizure? _____

_____

What causes your child to have seizures/more seizure activity? (check all that apply)
☐ Illness ☐ Fever ☐ Asthma medications ☐ Allergy medications
☐Other:_____
Please list all the medications your child takes at home and school for his/her diagnosis:
Name_____ Dose _____ Frequency _____
Name_____ Dose _____ Frequency _____
Name_____ Dose _____ Frequency _____

When your student misses a dose of medicine, what do you do? _____

Does your child feel any different if they forget to take medicine? _____

Does your child follow a ketogenic diet? ☐No ☐Yes If yes, parent will supply all food.

Are there any accommodations needed for your student regarding:
☐ Recess precautions ☐ Physical education precautions ☐ Special considerations for field trips/community trips ☐ Other: _____
How do you care for your child after a seizure?_____
_____

I understand that it is my responsibility to keep my child's school personnel informed of changes in my child's medical condition and to immediately notify them and complete a new form if treatment for the condition is changed or modified in any way. I understand information is to be updated annually with each school year.
I give permission for the nurse to communicate as warranted with the physician regarding my child's health concerns.

Signature: _____
Parent/Guardian Signature Month Day Year