



QUESTIONNAIRE FOR PARENT OF A STUDENT WITH SEIZURES

Please complete all questions. This information is essential for the school nurse and school staff in determining your student'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: _____
 School: _____ Grade: _____ Classroom: _____
 Parent/Guardian Name: _____ Tel. (H): _____ (W): _____ (C): _____
 Other Emergency Contact: _____ Tel. (H): _____ (W): _____ (C): _____
 Child's Neurologist: _____ Tel: _____ Location: _____
 Child's Primary Care Dr.: _____ Tel: _____ Location: _____

Significant medical history or conditions: _____

SEIZURE INFORMATION:

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

2. Seizure type(s):

<i>Seizure Type</i>	<i>Length</i>	<i>Frequency</i>	<i>Description</i>

3. What might trigger a seizure in your child? _____

4. Are there any warnings and/or behavior changes before the seizure occurs? YES NO
If YES, please explain: _____

5. When was your child's last seizure? _____

6. Has there been any recent change in your child's seizure patterns? YES NO
If YES, please explain: _____

7. How does your child react after a seizure is over? _____

8. How do other illnesses affect your child's seizure control? _____

BASIC FIRST AID: Care and Comfort Measures

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

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 (grand mal) seizure:

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

10. 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: _____

SEIZURE EMERGENCIES

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

- A Seizure is generally considered an Emergency when:
- ✓ A convulsive (tonic-clonic) seizure lasts longer than 5 minutes
 - ✓ Student has repeated seizures without regaining consciousness
 - ✓ Student has a first time seizure
 - ✓ Student is injured or diabetic
 - ✓ Student has breathing difficulties
 - ✓ Student has a seizure in water

12. Has child ever been hospitalized for continuous seizures? YES NO
 If YES, please explain: _____

SEIZURE MEDICATION AND TREATMENT INFORMATION

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

Medication	Date Started	Dosage	Frequency and time of day taken	Possible side effects

14. What emergency/rescue medications needed 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.

15. What medication(s) will your child need to take during school hours? _____
16. Should any of these medications be administered in a special way? YES NO
 If YES, please explain: _____
17. Should any particular reaction be watched for? YES NO
 If YES, please explain: _____
18. What should be done when your child misses a dose? _____
19. Should the school have backup medication available to give your child for missed dose? YES NO
20. Do you wish to be called before backup medication is given for a missed dose?
21. Does your child have a Vagus Nerve Stimulator? YES NO
 If YES, please describe instructions for appropriate magnet use: _____

SPECIAL CONSIDERATIONS & PRECAUTIONS

22. Check all that apply and describe any considerations or precautions that should be taken

- | | |
|---|---|
| <input type="checkbox"/> General health _____ | <input type="checkbox"/> Physical education (gym)/sports: _____ |
| <input type="checkbox"/> Physical functioning _____ | <input type="checkbox"/> Recess: _____ |
| <input type="checkbox"/> Learning: _____ | <input type="checkbox"/> Field trips: _____ |
| <input type="checkbox"/> Behavior: _____ | <input type="checkbox"/> Bus transportation: _____ |
| <input type="checkbox"/> Mood/coping: _____ | |
| Other: _____ | |

GENERAL COMMUNICATION ISSUES

23. What is the best way for us to communicate with you about your child's seizure(s)? _____

24. Can this information be shared with classroom teacher(s) and other appropriate school personnel? YES NO

Parent/Guardian Signature: _____ Date: _____ Dates Updated: _____



SEIZURE ACTION PLAN

Effective Date _____

THIS STUDENT IS BEING TREATED FOR A SEIZURE DISORDER. THE INFORMATION BELOW SHOULD ASSIST YOU IF A SEIZURE OCCURS DURING SCHOOL HOURS.

Student's Name: _____ Date of Birth: _____
Parent/Guardian: _____ Phone: _____ Cell: _____
Treating Physician: _____ Phone: _____
Significant medical history: _____

SEIZURE INFORMATION:

Seizure Type	Length	Frequency	Description

Seizure triggers or warning signs: _____

Student's reaction to seizure: _____

BASIC FIRST AID: CARE & COMFORT: (Please describe basic first aid procedures)

Does student need to leave the classroom after a seizure? YES NO
If YES, describe process for returning student 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 (grand mal) seizure:**
- ✓ Protect head
 - ✓ Keep airway open/watch breathing
 - ✓ Turn child on side

EMERGENCY RESPONSE:

A "seizure emergency" for this student is defined as: _____

Seizure Emergency Protocol: (Check all that apply and clarify below)

- Contact school nurse at _____
- Call 911 for transport to _____
- Notify parent or emergency contact _____
- Notify doctor _____
- Administer emergency medications as indicated below
- Other _____

- A Seizure is generally considered an Emergency when:
- ✓ A convulsive (tonic-clonic) seizure lasts longer than 5 minutes
 - ✓ Student has repeated seizures without regaining consciousness
 - ✓ Student has a first time seizure
 - ✓ Student is injured or has diabetes
 - ✓ Student has breathing difficulties
 - ✓ Student has a seizure in water

TREATMENT PROTOCOL DURING SCHOOL HOURS: (include daily and emergency medications)

Daily Medication	Dosage & Time of Day Given	Common Side Effects & Special Instructions

Emergency/Rescue Medication _____

Does student have a Vagus Nerve Stimulator (VNS)? YES NO
If YES, Describe magnet use _____

SPECIAL CONSIDERATIONS & SAFETY PRECAUTIONS: (regarding school activities, sports, trips, etc.)

Physician Signature: _____ Date: _____

Parent Signature: _____ Date: _____

Klein Independent School District

Central Office
7200 Spring-Cypress Road
Klein, Texas 77379-3299
832.249.4000

Instructional Center
4411 Louetta Road
Spring, Texas 77388-4414
832.249.5000

DIAZEPAM RECTAL GEL (DIASTAT) ORDERS

Student's Name: _____
Last First

DOB: _____ Grade: _____ ID#: _____

School Year: _____

Procedure for Administration of Diazepam Rectal Gel (Diastat):

1. Diazepam Rectal Gel (Diastat) Dosage: _____
2. Indications for treatment (be very specific) including length of time seizure should last before treatment begins: _____

3. Side effects expected after the administration of medication: _____

4. Action to be taken if child has bowel movement or expels medication: _____

5. Should medication be given if child has fever, respiratory infection or cold: _____
6. Protocol is to call 911 after administering Diazepam Rectal Gel (Diastat) unless specifically ordered otherwise (and always after initial dose of this drug). Please explain in detail any circumstances where it is not necessary to call 911:

7. **Please note: if prolonged seizure occurs at any time when a school nurse (RN) is not available, 911 will be called.**

Printed name of physician: _____

Physician's signature: _____

Physician's phone number: _____ Fax: _____

Date: _____

I request that Diazepam Rectal Gel (Diastat) be administered to my child according to the signed protocol from my physician.

I hereby give my permission for the school nurse to consult with the prescribing physician regarding the above orders.

Parent's Signature _____ Date: _____

Emergency phone numbers: _____