ACCEPT
Education Collaborative

220 North Main Street, Suite 201, Natick, MA 01760
508.653.6776 • 508.653.0878 Fax • accept.org

QUESTIONNAIRE FOR PARENTS OF CHILD WITH SEIZURE DISORDER
School Year 2016-2017

Student's Name:_____ **DOB:**_____

School:_____ **Grade**:_____

Classroom:_____ **Teacher**:_____

Mother's Name: _____ **Phone (home**):_____ **(work**):_____

(cell): _____

Father's Name:_____ **Phone (home**):_____ **(work)**:_____

(**cell): _____**

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The following information will be helpful to the school nurse and school staff in determining appropriate care for your child's special needs. Please complete all questions.

1. When was your child's first seizure?_____ Does your child continue to have active seizures?_____

2. Is there a difference between past and current seizure patterns? If so, how have they changed?_____
_____

3.Describe:

- Seizure type:
  _____
- Describe what your child's seizure looks like:_____
  _____
- What triggers the seizure?_____
- How long does seizure typically last?_____
- Are there any warnings and/or behavior changes before the seizure (ex. agitation, headache, blurred vision):
  _____
- Average frequency: daily? weekly? monthly? yearly?:_____
- Usual time of day seizure(s) occur:_____
- Date of last seizure:_____
- Student's reaction to seizure(s) (ex. lethargic, nausea, vomiting,):_____

4 .When your child is sick, does the frequency of seizure (s) increase?_____

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5. What medication(s) does your child take for seizure control?

Medication	Dosage	Frequency & Time of Day

6. Does your child require emergency medications to treat long lasting seizure? □ Yes □ No
If yes, what medication and dosage? _____

7. Will your child need to have medications administered during school hours? _____ If yes, complete below:

- Should the medication be administered in a special way? _____
- Should any particular reaction be watched for?_____

8. Does taking other medication(s) affect your child's seizure control?_____

9. What happens when your child misses a dose?_____

10. List any special considerations related to your child's epilepsy while at school and describe them briefly.

- Educational concerns:_____
- Behavioral concerns: _____
- Emotional concerns:_____
- Physical Education/Sport precautions:_____
- Special considerations for field trips/transportation:_____
- Other:_____

11. How often does your child see their doctor regarding seizures?_____

- When was his/her last appointment?_____

12. The physician treating your child's seizures is:

Name:_____
Address: _____
Phone Number:_____

13. Does your child have other recurring or chronic health problems?_____

Parent/Guardian Signature:_____Date: _____