PITTSFORD CENTRAL SCHOOL DISTRICT
Parent Interview Questionnaire for Individualized Health Plan
SEIZURE ACTIVITY

Child’s Name ___________________________ Birthdate ______ Age _____ Grade _____
Teacher __________________ Information provided by ___________ Date __________

Please answer all questions. Use the back of this form for explanation or any additional information you feel important for us to know.

Who does your child see for regular health visits? ______________________ Phone __________
Who does your child see for seizure management? ______________________ Phone __________

When was your child diagnosed with seizure disorder? ______________________ at age ________
Has your child been diagnosed with any other medical conditions?
☐ No ☐ Yes (explain) __________________________

What symptoms does your child experience during a seizure? __________________________

Is your child aware of an aura (distortion of vision, hearing or smell) before a seizure? ________

How would your child describe any of the above symptoms? __________________________

Does your child lose consciousness during a seizure? __________________________

How often does your child experience a seizure? __________________________

How long does your child’s seizure typically last? __________________________

When was your child’s last seizure (date/time/duration)? __________________________

Has your child experienced a seizure lasting longer than five minutes? ________ at age ________

Has your child ever gone to the emergency room or been hospitalized for his/her seizures?
☐ No ☐ Yes (explain) __________________________

What events might trigger a seizure for your child? __________________________

What medications does your child take to manage his/her seizure disorder?

<table>
<thead>
<tr>
<th>Name of medication</th>
<th>Amount</th>
<th>When taken</th>
</tr>
</thead>
<tbody>
<tr>
<td>_________________</td>
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</tbody>
</table>

Has your child been instructed on when and how to take these medications independently?
☐ No ☐ Yes

Are there any side effects from your child’s medications that his/her teacher needs to be aware of?
☐ No ☐ Yes (explain) __________________________

Is your child participating in sports or school sponsored extra-curricular activities?
☐ No ☐ Yes

What are your child’s feelings about having a seizure disorder? __________________________

Is your child comfortable alerting others when experiencing symptoms of a possible seizure?
☐ No ☐ Yes

Does your child wear a “medic alert” necklace/bracelet?
☐ No ☐ Yes

Do you feel your child’s understanding of his/her seizure disorder is?
☐ very good ☐ good ☐ fair ☐ limited

Has your physician indicated in writing that your child needs any special accommodations in school?
☐ No ☐ Yes (explain) __________________________

Comments: __________________________

____________________________________

Seizure Questionnaire / 8/02
# EMERGENCY CARE PLAN: TONIC CLONIC SEIZURE DISORDER

**To be completed by Parent**

<table>
<thead>
<tr>
<th>Student:</th>
<th>Grade:</th>
<th>Teacher/HR:</th>
<th>Birth Date:</th>
</tr>
</thead>
</table>

- **Diabetic:** [ ] yes [ ] no
- **Mother’s Name:**
- **Home#: | Work#: | Cell#: |
- **Father’s Name:**
- **Home#: | Work#: | Cell#: |

I give permission to share this plan with physician and school staff. I agree with the physician’s orders as outlined below.

**Parent Signature __________________________ Date ______________

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## SIGNS OF A GENERALIZED TONIC CLONIC SEIZURE (GRAND MAL) MAY INCLUDE:

- Sudden loss of consciousness
- Fall to the ground, sometimes with a cry
- Entire body usually becomes rigid, then jerking of the face, trunk and limb ensues
- Bladder control may be lost
- Breathing may be shallow or may even stop
- When seizure activity stops, the child may be confused, drowsy or complain of headache

## EMERGENCY PLAN IN THE EVENT OF A SEIZURE:

- Clear the area
- Ease child gently to the floor, gently turn on side and place blanket or soft flat object under head
- Loosen any tight clothing around the neck
- **Do not** restrain movements or put anything in the mouth
- Check time to note what time seizure started
- Reassure child when he/she wakes up
- On bus, lay across a double or triple seat and proceed as above
- Contact school nurse at ____________ and parent.

If a single seizure lasts less than 5 minutes, no other medical assistance is usually needed. If there are multiple seizures or if one seizure lasts longer than 5 minutes, call 911. Breathing may be shallow during a seizure and may even stop. This can give the child’s lips or skin a bluish tinge, which corrects naturally as the seizure ends. In the unlikely event that breathing does not begin again, check the child’s airway for obstruction and begin CPR.

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**To be completed by Physician**

<table>
<thead>
<tr>
<th>Diagnosis (Type of Seizures)</th>
<th>Other Diagnoses</th>
<th>Allergies:</th>
</tr>
</thead>
</table>

**Treatment prescribed**

- medication(s)/dose/route

**Activity Restrictions Needed**

- [ ] No
- [ ] Yes (explain)

I agree with this plan (check one)

- [ ] as written
- [ ] with the following modifications:

<table>
<thead>
<tr>
<th>Doctor Name (Please Print):</th>
<th>Phone:</th>
<th>Fax:</th>
</tr>
</thead>
</table>

**Doctor Signature: __________________________ Date: ______________

This plan is in effect for the current school year.

Please return to __________________________ Phone # __________________ Fax # __________________

Seizure Questionnaire / 8/02