Katy Independent School District
Health Services Department

Parent Questionnaire for a Student with Seizures

Please complete all questions. This information is essential for the school nurse and school staff in determining your child'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 campus nurse.

Contact Information		
Student Name	School Year	Date of Birth
School	Grade	Classroom
Parent Guardian	Phone	Phone
Parent/Guardian Email		
Other Emergency contact	Phone	Phone
Child's Neurologist	Phone	Location
Child's Primary Care Doctor	Phone	Location
Significant Medical History or Conditions		

Seizure Information

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

2. Seizure type(s)

Seizure Type	**Length (How long it lasts)**	**Frequency (How often)**	**What happens during a seizure**

3. What might trigger a seizure in your child? CIRCLE ALL THAT APPLY:

Missed Medicine | Physical Stress | Illness with High Fever | Emotional Stress
Flashing Lights | Alcohol/Drugs | Lack of Sleep | Missing Meals
Menstrual Cycle

Other Triggers: _____

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

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

6. Is your child able to manage & understand their seizures? (Circle YES or NO) YES NO

7. Has there been any recent change in your child's seizure patterns? (Circle YES or NO) YES NO
   If YES, please explain: _____

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

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

_____

Basic First Aid: Care & Comfort

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

11. Will your child need to leave the classroom after a seizure? (Circle YES or NO) YES NO

12. If YES, what process would you recommend for returning your child to classroom.

_____

Basic Seizure First Aid

- Stay calm & **track time.**
- Keep child safe, remove harmful objects, **do not restrain, and protect the head.**
- Turn the student on their **side** if not awake, keep airway clear, **do not put objects in mouth.**
- Stay with child until fully recovers.
- **Record s**eizure in log.

Seizure Emergencies

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

12. Has child ever been hospitalized for continuous seizures? (Circle YES or NO) YES NO

13. If YES, please explain: _____

_____

_____

SEIZURE EMERGENCY PROTOCOL FOR KATY ISD - DISTRICT PERSONNEL TO FOLLOW

- Administer emergency medications
- Contact campus nurse _____
- Call 911; transport to_____
- Notify parent or emergency contact
- Other:_____

A seizure emergency-when to call 911 for the student

- Seizure with a loss of consciousness longer than 5 min and not responding to rescue medicine if available.
- Student has repeated seizures, lasting longer than 10 min. with no recovery between them and the student is not responding to available rescue medicine.
- Student is injured.
- Student has a first-time seizure.
- Student has breathing difficulties.
- Student has a seizure in water.

Seizure Medication and Treatment

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 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? (Circle YES or NO) YES NO

If YES, please explain: _____

17. Should any particular reaction be watched for? (Circle YES or NO) 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? (Circle YES or NO) YES NO

20. Do you wish to be called before backup medication is given for a missed dose? (Circle YES or NO) YES NO

21. Does your child have a Vagus Nerve Stimulator (VNS)? (Circle YES or NO) YES NO

VNS/Device : (Circle) VNS RNS DBS

Date Implanted : _____

Describe instructions for appropriate magnet use:

_____

Special Considerations & Precautions

13. Check all that apply and describe any consideration or precautions that should be taken:

	General Health		Physical education (gym/sports)
	Physical functioning		Recess
	Learning		Field Trips
	Behavior		Bus transportation
	Mood/coping		Other

General Communication Issues

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

15. Can this information be shared with classroom teacher(s) and other appropriate school personnel?

(Circle YES or NO)

Health Care Contacts

Epilepsy Provider:_____ **Phone**:_____

Primary Care: _____ **Phone:** _____

Preferred Hospital: _____ **Phone:** _____

Parent/Guardian Signature: _____ **Date:** _____