Seattle Public Schools

SEIZURE ASSESSMENT CHECKLIST

Student's Name: _____ **School Year:** _____

Date of Birth: _____ **Grade:** _____ **School:** _____ **Classroom:** _____

Parent/Guardian: _____ Phone: _____

Work Phone: _____ Cell Phone: _____

Parent/Guardian Email: _____ Preferred Language: _____

Other Emergency Contact: _____ Phone: _____

Work Phone: _____ Cell Phone: _____

Child's Neurologist: _____ Phone: _____

Location: _____

Child's Primary Care Doctor: _____ Phone: _____

Location: _____

Significant Medical History or Conditions:

_____

Who should the school nurse call/text if there is a health concern during the school day?

_____	_____	_____
Name	Relationship	Phone number
_____	_____	_____
Name	Relationship	Phone number

SEIZURE INFORMATION

When was your child diagnosed with seizures or epilepsy? _____

Seizure Type	Length	Frequency	Description

Continue on next page

What might trigger a seizure in your child? _____

Are there any warning and/or behavior changes before the seizure occurs? ☐ No ☐ Yes

If YES, please explain: _____

When was your child's last seizure? _____

Has there been any recent change in your child's seizure patterns? ☐ No ☐ Yes

If YES, please explain: _____

When was your child's last seizure? _____

How does your child react after a seizure is over: _____

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

BASIC FIRST AID: CARE & COMFORT

Will your child need to leave the classroom after a seizure? ☐ No ☐ Yes

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

_____

SEIZURE EMERGENCIES

Please describe what constitutes an emergency for your child (Answer may require consultation with treating health care provider and school nurse. ***Please note school nurse will follow current health care provider orders***. Describe below.

_____

Has child ever been hospitalized for continuous seizures? ☐ No ☐ Yes

If YES, please explain. Describe below.

_____

SEIZURE MEDICATION AND TREATMENT INFORMATION

What medication does your child take?

Medication	Dosage	Frequency and Time of Day Taken	Possible Side Effects

Continue on next page

What emergency/rescue medications are prescribed for your child?

Medication	Dosage	Administration Instructions (timing* & method**)	What to Do After Administration

What medication(s) will your child need to take during school hours? _____

Should any of these medications be administered in a special way? ☐ No ☐ Yes

If YES, please explain_____

Should any specific reaction be watched for? ☐ No ☐ Yes

If YES, please explain_____

What should be done when your child misses a dose (at home or school)?

_____

Should the school have backup medication available to give your child for a missed home dose?

☐ No ☐ Yes

Does your child have a Vagus Nerve Stimulator? ☐ No ☐ Yes

If YES, please describe instructions for appropriate magnet use:

_____

_____

SPECIAL CONSIDERATIONS & PRECAUTIONS

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

☐ General health _____
☐ Physical functioning _____
☐ Learning _____
☐ Behavior _____
☐ Mood/coping _____
☐ Physical education _____
☐ Recess _____
☐ Field Trips _____
☐ Bus transportation _____
☐ Cultural/religious concerns _____

Parent/Guardian Signature: _____ Date:_____

School Nurse Signature: _____ Date:_____

Updated: _____

SEIZURE LOG- STAFF TO FILL OUT WHILE STUDENT IS AT SCHOOL

Date										
Time										
Duration										
Lip Smacking										
Clenched Teeth										
Fixed Gaze										
Eyes Turned Up										
Eyes Turned Right										
Eyes Turned Left										
Body Rigid										
Jerking Right Arm										
Jerking Left Arm										
Jerking Right Leg										
Jerking Left Leg										
Body Jerked Rhythmically										
Fell										
Unconscious (Minutes)										
Slept (Minutes)										
Incontinent										
VNS Magnet (x1, x2, x3)										
Staff Initials										