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 education _____

☐ Physical functioning _____ ☐ Recess _____

☐ Learning _____ ☐ Field Trips _____

☐ Behavior _____ ☐ Bus transportation _____

☐ Mood/coping _____ ☐ Cultural/religious concerns _____

Parent/Guardian Signature: _____ Date:_____

School Nurse Signature: _____ Date:_____

Updated: _____