Intermediate School District 917
Health Information for Student with Seizures

Student _____ **Birth Date** _____ **School Year** _____

Diagnosis _____ **ICD10 code** _____

Is your child currently receiving treatment for seizure control? _____Yes _____No If yes, indicate below:

- ❑ Medication management (List medication(s)
- ❑ Diet _____
- ❑ Vagus Nerve Stimulator (VNS) _____
- ❑ Other (name) _____

1. **What is the likelihood of seizures occurring during school hours?** _____

   Date of last seizure _____

2. **Does your child require safety equipment related to seizure activity?**
   - ❑ Yes **(If yes, what)** _____
   - ❑ No

3. **Has your child ever turned blue around the lips and/or fingernails with a seizure?**
   - ❑ Yes **(If yes, explain)** _____
   - ❑ No

4. **Has your child ever had a seizure: (Please check the following, if applicable?)**

   - ❑ lasting over 5 minutes and/or
   - ❑ had seizures one right after another and/or
   - ❑ that required emergency treatment or seizure rescue medication to stop the seizure

   If yes, please describe _____

5. **Seizure triggers or warning signs** _____

6. **Seizure event types: (Please check and briefly describe.)**

   - ❑ Absence (staring)-describe _____

     length _____ (sec/min) frequency _____ (daily/weekly/monthly)

   - ❑ Simple Partial-describe _____

     length _____ (sec/min) frequency _____ (daily/weekly/monthly)

   - ❑ Complex Partial-describe _____

     length _____ (sec/min) frequency _____ (daily/weekly/monthly)

   - ❑ Generalized Tonic Clonic (grand mal)-describe _____

     length _____ (sec/min) frequency _____ (daily/weekly/monthly)

   - ❑ Tonic-describe _____

     length _____ (sec/min) frequency _____ (daily/weekly/monthly)

   - ❑ Atonic (drop)-describe _____

     length _____ (sec/min) frequency _____ (daily/weekly/monthly)

   - ❑ Unknown Type-describe _____

     length _____ (sec/min) frequency _____ (daily/weekly/monthly)

7. **Student's response after a seizure** _____

8. **Other information regarding seizure events** _____

Parent/Guardian Signature _____ **Date** _____

For office use only:
LSN Signature _____ Date: _____
Name of Staff Routing _____ Date: _____
Please check off who was routed this form ___Student File _____ IEP Manager ___ 917 LSN ___Building Nurse