Student Services Department
181 Encinal Avenue, Atherton, CA 94027
(650) 321-7140 Fax: (650) 292-2200

SEIZURE QUESTIONNAIRE

Please return this form to the school office immediately. Call the school nurse if you want to discuss this further.

Date _____

Check Site: ☐ Heritage Oak ☐ Laurel ☐ Encinal ☐ Oak Knoll ☐ Hillview

Please print:

Student: _____ Grade _____

Teacher: _____ Room _____

Parent phone_____ Emergency phone #_____

School records indicate that your child has a seizure disorder. In order to help us provide the best care for your child, please complete the following information.

1. What type of seizure does your child have?
   ☐ Generalized ☐ Convulsive/Grand Mal
   ☐ Partial Complex ☐ Absence/Petit Mal
2. Age of child when diagnosed with seizures/epilepsy:_____
3. When was the last seizure?_____
4. How often does your child have a seizure?_____
5. How long does the seizure last?_____
6. Description of seizure (for example, affects both sides of body, affects one body part, does child lose consciousness or black out). Use other side if needed. _____

   _____
7. What seizure medications does your child take? Use other side if needed.
   Medication:_____ Dose_____ Time_____
   Medication:_____ Dose_____ Time_____
8. What is your child's behavior after a seizure (for example, sleepy disoriented, confused, upset)?

   _____
9. If your child needs medication at school, a *Medication Authorization Form* must be completed and returned to the school office with the medication. The Medication Authorization Form may be found on the district web site at district.mpcsd.org.

Form filled out by _____ _____ _____
Signature **Telephone** **Date**

_____ Relationship to student: _____
Print Name