Parent/Guardian Questionnaire for Students with Seizures
Coatesville Area School District

In order to give the appropriate care, we request that you complete this form and return it to the School Nurse. If there is any change in this information during the school year, please notify the school nurse <u>in writing</u>.

Student Name:_____School:_____

School Year:_____ Grade:_____ Homeroom/Advisory:_____

When did your student start experiencing seizures? _____

Symptoms that student experiences BEFORE and AFTER seizure: _____

_____

Frequency of seizures: _____

Date of last seizure: _____Length of seizures: _____

Type ofeizure:_____
__
Description of seizure:_____

Medications:

Commented [LC1]: e

Control Medication(s):
Name: _____ Dose/Frequency: _____
Name: _____ Dose/Frequency: _____
Name: _____ Dos/Frequency: _____

Special Instructions: _____
_____
_____

PLEASE REFER TO THE MEDICATION POLICY/PERMISSION FORM IF MEDICATION IS NEEDED AT SCHOOL

Name of Physician _____ Phone Number _____

I understand the above information will be used in an emergency action plan for my child. I give my permission to share this plan with my child's assigned teachers and appropriate personnel.

Signature of Parent/Guardian_____ Date_____