Hempfield School District
Landisville, Pennsylvania
Seizure Questionnaire

Student: _____ DOB: _____ Teacher:_____Grade: _____

Name of Physician treating seizure: Phone #: _____

1. What does the seizure look like? How often do they occur?_____

   _____

   _____

2. How long does it last? Seconds? Minutes?_____

3. What is the date of your child's last seizure? _____

4. At what age was your child first diagnosed with seizure disorder? _____

5. Describe your child's symptoms **during** and **after** the seizure? _____

   _____

6. Does your child have a warning of the seizure coming? Is he/she able to notify anyone of an impending seizure? _____

   _____

7. List medication(s) taken, dose and frequency:

   at home_____ at school_____

   ****Requests for administration of medication forms signed by the parent and physician are required for all medications given at school including anticonvulsants and Diastat. Please refer to district medication policy.**

8. Does your child have any side effects from these medications?_____

   _____

9. Are there any sports/activities in which your child cannot fully participate?_____

10. Please provide any other information you feel would be beneficial for your child at school._____

    _____

You are encouraged to alert all other school personnel (transportation department, child nutrition department, etc.) that may have contact with your child, so that they are aware of your child's diagnosis and the treatment that may be required during school hours.

Parent Signature:_____Date:_____

10/09