Sioux City Community Schools
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Questionnaire for Parents of a Child with Seizure Disorder

Student Name: _____ **DOB:** _____

To Parent / Guardian:
The following information is helpful to your child's school nurse and school staff in determining any special needs for your child. Please answer the questions to the best of your ability. The school nurse will be writing a seizure classroom health plan for your child if applicable. You will receive a copy of the health plan for your approval.

1. How long has your child had a seizure disorder? _____

2. What type of seizure disorder does your child have?

   a. _____ GeneralizedTonic-Clonic (Grand Mal)
   b. _____ Absence (Petit Mal)
   c. _____ Simple Partial
   d. _____ Complex Partial (Psychomotor or Temporal Lobe)
   e. _____ Atonic (Drop Attacks)
   f. _____ Myoclonic
   g. _____ Febrile

3. Does your child have an aura or warning signals before a seizure? i.e. dizziness, light flashes, unusual tastes, smells or sounds, etc.)
   _____

4. How long does the seizure usually last?_____

5. What medication does your child take and how many times a day?
   _____

6. Will your child need to take the medication during school hours? YES NO

7. What if any, side effects does your child have from the medication(s)?
   _____

8. Name of your child's doctor for seizures? _____

9. How often does your child see his/her doctor for routine seizure evaluations?
   _____

10. What if any physical activity restrictions does your child have?
    _____

11. Additional information/Special instructions/Comments/Concerns:
    _____
    _____
    _____

Parent/Guardian Signature_____ Date_____