

**JERICHO PUBLIC SCHOOLS**  
**Seizure Questionnaire**

Student's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Grade \_\_\_\_\_ Home Phone \_\_\_\_\_  
Mother's Phone \_\_\_\_\_ Father's Phone \_\_\_\_\_  
Pediatrician \_\_\_\_\_ Phone \_\_\_\_\_  
Neurologist \_\_\_\_\_ Phone \_\_\_\_\_

When was your child's first seizure? \_\_\_\_\_  
Describe your child's first seizure?  
\_\_\_\_\_  
\_\_\_\_\_

Has there been any change in the type of seizures your child has? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, please describe the change \_\_\_\_\_  
\_\_\_\_\_

Diagnosis: \_\_\_\_\_  
Current Medications: \_\_\_\_\_  
\_\_\_\_\_

Last EEG? \_\_\_\_\_  
Findings: \_\_\_\_\_  
\_\_\_\_\_

Is your child currently having seizures? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, how often? \_\_\_\_\_  
When was last seizure? \_\_\_\_\_  
Is your child aware of their diagnosis? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, how was it explained to him/her? \_\_\_\_\_  
\_\_\_\_\_

Does your child experience any side effects from their medication? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, what are they? \_\_\_\_\_  
\_\_\_\_\_

Does your child have any other medical problems? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, what are they? \_\_\_\_\_  
\_\_\_\_\_

Has your child been hospitalized with his/her seizures? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, when and for how long? \_\_\_\_\_  
\_\_\_\_\_

When is your child's next neurological exam? \_\_\_\_\_

Your child's health concerns will always be handled with the utmost of concern and confidentiality. Due to health and safety concerns it may be necessary to share your child's concerns with school staff on a need to know basis. If your child rides a bus to and from school it may also be necessary for our District Transportation to be made aware of your child's diagnosis.

I \_\_\_\_\_ parent of \_\_\_\_\_  
give permission to the school nurse to share medical information with appropriate school personnel and district transportation.

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date