Seizure History **STUDENT NAME**_____ **DATE** _____

The following form will assist the school nurse and staff in determining any special needs for your child and the development of an individualized healthcare plan (IHP). This form is to be completed at initial IHP development and every 2 years thereafter. If you desire a conference with the school nurse, please call your child's school for an appointment.

1. **Does your child have a diagnosis of seizures from a healthcare provider:** ☐ **No** ☐ **Yes**
   Managing physician: _____ Phone:_____

2. **History of Current Status**
   a. Are there triggers for your child's seizures? ☐ No ☐ Yes If yes, explain:_____
      _____
   b. What type of seizures does your child have? _____
   c. Please list all medications your child takes: _____
   d. Age of child when seizures first began:_____
   e. How often does your child have a seizure: _____
   f. Describe past seizures: _____
   g. Over time, are the seizures: ☐Same ☐Better ☐Worse

3. **Symptoms**
   a. What are the early signs and symptoms of your child's seizure? *(Be specific; include things the* child *might do.)*
      _____
   b. How does your child communicate his/her symptoms? _____
   b. How long do the seizures usually last: _____seconds _____minutes
   c. Please check the symptoms that your child has experienced in the past:

Skin	Mouth	Limbs	Throat/Face	Lungs	Heart
☐ **Pale**	☐ **Twitching**	☐ **Jerking**	☐ **Choking**	☐ **Difficulty breathing**	☐ **Weak pulse**
☐ **Flushing**	☐ **Pulls to side**	☐ **Stiffening**	☐ **Staring**	☐ **Stops breathing**	☐ **Loss of consciousness**
☐ **Lips turn blue**	☐ **Drool**	☐ **Flailing**	☐ **Blank look**		
		☐ **Drop/no muscle tone**	☐ **Unresponsive to commands**		

4. **Treatment**
   a. How have past seizures been treated? _____
   b. What was the child's response to treatment? _____
   c. Was there an emergency room visit? ☐ No ☐ Yes, explain:_____
   d. Was the child admitted to the hospital? ☐ No ☐ Yes, explain: _____
   e. What emergency treatment or medication has your healthcare provider recommended for use in a seizure?
      _____
   f. Has your healthcare provider provided you with a prescription for this medication? ☐ No ☐ Yes
   g. Have you ever used the emergency treatment or medication? ☐ No ☐ Yes
   h. Please describe any side effects or problems your child had in using the suggested treatment:
      _____

**Continued on reverse

5. **Family/Home**
    a. How do you feel that the whole family is coping with your child's seizure disorder? _____
    _____
    b. Do you or your child carry emergency medicine in the event of a seizure? ☐ No ☐ Yes
    c. Has your child ever needed the emergency medicine away from home? ☐ No ☐ Yes
    d. Do you feel that your child needs assistance in coping with his/her seizure disorder? ☐ No ☐ Yes

6. **General Health**
    a. How is your child's general health other than having a seizure disorder?_____
    b. Does your child have other health conditions? _____
    c. Has your child ever been hospitalized for any reason?_____
    d. Please add anything else you would like the school to know about your child's health:
    _____

7. **Notes:**

_____
_____
_____
_____
_____
_____
_____
_____
_____

Parent/Guardian Signature:_____ **Date:**_____

Reviewed by:_____ **Date:** _____