AUBURN UNION SCHOOL DISTRICT
255 EPPERLE LANE
AUBURN, CA 95603
PHONE 530.885.7242
FAX 530.885.5170

SEIZURE INFORMATION

Dear Parent/Guardian,
Please complete the following questions. This information is essential for the district nurse and school staff in determining your child's special needs and providing a positive and supportive learning environment. If you have any questions about how to complete this form, please contact Jenny Serrano, District Nurse (jserrano@auburn.k12.ca.us)

Student Information		
Student Name:	**DOB:**	**School Year:**
School:	**Grade:**	
Student's Neurologist:		
Student's Primary Care Doctor:		

Seizure Information			
How old was your child when they had their first seizure? _____ **When was your child first diagnosed with seizures of epilepsy? _____**			
Please describe your child's seizures:			
Seizure Type	**Length**	**Frequency**	**Description**

●**What might trigger a seizure in your child? _____**

●**Are there any warnings and/or behavior changes before the seizure occurs**? ❒ Yes ❒ No

If yes, please explain: _____

●**When was your child's last seizure?**_____

●**Has there been any recent change in your child's seizure patterns?** ❒ Yes ❒ No

If yes, please explain:

_____

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SEIZURE INFORMATION (CONTINUED)

●**How does your child react after a seizure is over?**

_____

●**How do other illnesses affect your child's seizure control?**

_____

●**Has child ever been hospitalized for continuous seizures?** ❒ Yes ❒ No
If yes, please explain:

_____

●**Does your child have a vagus nerve stimulator?** ❒ Yes ❒ No
If yes, please describe instructions for appropriate magnet use:

_____

Basic First Aid: Care & Comfort	**Basic Seizure First Aid**
What basic first aid procedures should be taken when your child has a seizure at school? (*Standard care plan interventions on right*) **Will your child need to leave the classroom after a seizure?** ❒ Yes ❒ No **If yes, what process would you recommend for returning to classroom?**	●Stay calm and track time ●Keep child safe (protect head, turn on side) ●Do not restrain ●Do not put anything in mouth ●Stay with child until fully conscious ●Closely monitor airway and breathing ●Record seizure in log

Seizure Emergencies	**A seizure is generally considered an emergency when:**
Please describe what constitutes an emergency for your child? (*Answers may require consultation with treating physician and district nurse*) **Has your child ever been hospitalized for continuous seizures?** ❒ Yes ❒ No **If yes, please explain and provide date:**	●Convulsive (tonic-clonic) seizure lasts longer than 5 minutes ●Student has repeated seizures without regaining consciousness ●Student is injured or has diabetes ●Students has first-time ●Students has breathing difficulties ●Student has seizure in water

Special Considerations	
Please describe any special considerations that might need to be addressed during the following:	
PE	
Recess	
Field Trips	
Bus Transportation	

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SEIZURE INFORMATION (CONTINUED)

Medication and Treatment Information			
What medication(s) does your child take?			
Medication	**Dosage**	**Frequency/Time of Day**	**Date Started**
What emergency/rescue medications are prescribed for your child?			
Medication	**Dosage**	**Administration Instructions**	**Follow Up Care Needed**

●**Does your child need to keep medication at school?** ❒ Yes ❒ No

If yes, please complete the attached ***Medication In School*** or ***Diastat Procedure and Order*** form and return it to the School Nurse

General Communication
What is the best way for school staff to communicate with you about your child's seizures?
Can this information be shared with classroom teacher(s) and other appropriate school personnel? ❒ Yes ❒ No

●**Any other concerns or comments you would like to share with the district nurse?**

_____

_____

Parent/Guardian Name:_____ **Date:**_____

Thank you for your assistance. The district nurse will review this information and develop a personalized seizure action plan for your student. This plan will be sent to you to review and approve before sent to appropriate school staff.

FOR OFFICE USE ONLY		
Date Rec:	**F/U Needed:** ❒ Yes ❒ No	**SAP :** ❒ Yes ❒ No