SUMTER COUNTY SCHOOLS - SCHOOL HEALTH SERVICES
SEIZURES - PARENT INTERVIEW GUIDE

Please complete this form with as much accurate information as possible. The information provided is used to develop an individualized health care plan for your child to promote a safe environment with a goal to maintain optimal health. Important: Include correct numbers where you can be reached.

Student's Name: ______________________________ Date of Birth: ________ School: _________
Student's Address: ____________________________ Grade: _____ Teacher: _________________
Parent/Guardian: ____________________________ Phone #1: ___________________________
____ Phone #2: ___________________________
Emergency Contacts: __________________________ Phone #1: ___________________________
____ Phone #2: ___________________________
Prescribing Doctor: _________________ Phone: _____________ Fax: _____________________
Preferred Hospital: ___________________________ Allergies: ___________________________

1. Medical diagnosis: ______________________ Type of seizure: ________________________
2. How long has this condition existed? ______ Has student ever been hospitalized due to a seizure? _____
3. How often does the seizure activity occur? ____
4. How long does the seizure activity usually last? ______________________________________
5. What triggers your child's seizures (if known)? ______________________________________
6. Has your child ever suffered a seizure that lasted more than 5 minutes? If so how was it handled?
   ________________________ Was your child hospitalized at that time? ____________________
7. What kind of seizure symptoms does your child experience? ____________________________
8. What medication(s) does your child take (List all Medications)? ________________________
9. Does your child lose bowel or bladder during seizure? __________________________________
10. Has your child ever turned blue or stopped breathing during a seizure? ____ If yes, how was it handled?
    ____
10. Any limitations to activities or any protective equipment, (helmet) needed? If yes list and explain.
    ____
11. Does your child have a Vagus Nerve Stimulator? Yes ______ No ______ If yes, any special instructions?
    ____
12. What is your child's understanding of his/her condition? _____________________________
13. Any other information or special instructions? _______________________________________

As parent/guardian by signing this form, I give permission for Sumter County Schools to share this information with the faculty and staff who are directly involved in my child's education and/or school health services.

___________________________ ___________________________ ___________
Parent signature Please Print name Date