District Letterhead

**Parent Interview Questionnaire for Seizure History**

Child’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate \_\_\_\_\_\_\_\_\_ Age \_\_\_\_\_\_\_\_ Grade\_\_\_\_\_\_\_\_\_\_ Teacher\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Information provided by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_

**Please answer all questions. Use the back of this form for explanation or any additional information.**

Who does your child see for regular health visits? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who does your child see for seizure management? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_

When was your child diagnosed with seizure disorder? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_at age \_\_\_\_\_\_\_\_\_\_\_

Has your child been diagnosed with any other medical conditions? ❑ No ❑ Yes (Please explain)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What symptoms does your child experience during a seizure \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is your child aware of an aura (distortion of vision, hearing or smell) before a seizure \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What words would your child use to describe the above symptoms \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child lose consciousness during a seizure? ❑ No ❑ Yes

How often does your child experience a seizure? \_\_\_\_\_ x a month \_\_\_\_\_ x a day other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long does your child’s seizure typically last? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When was your child’s last seizure (date/time/duration)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child experienced a seizure lasting longer than five minutes? ❑ No ❑ Yes (Please explain)

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Has your child ever gone to the emergency room or been hospitalized for his/her seizures? ❑ No ❑ Yes

(Please explain)

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What events might trigger a seizure for your child? ­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What medications does your child take to manage his/her seizure disorder?

Name of medication \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Amount\_\_\_\_\_\_\_\_\_\_\_ When taken\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child been instructed on when and how to take these medications independently? ❑ No ❑ Yes

Are there any side effects from your child’s medications that his/her teacher needs to be aware of? ❑ No ❑ Yes (Please explain)

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Is your child participating in sports or school sponsored extra-curricular activities? ❑ No ❑ Yes (Please explain)

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What are your child’s feelings about having a seizure disorder? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is your child comfortable alerting others when experiencing symptoms of a possible seizure? ❑ No ❑ Yes

Does your child wear a “medic alert” necklace/ bracelet? ❑ No ❑ Yes

Describe your child’s understanding of their seizure disorder? ❑ None /Limited ❑ Basic ❑ Knowledgeable

Has your medical provider indicated in writing that your child needs special accommodations in school?

❑No ❑ Yes (Please explain)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sample Seizure History Questionnaire NYSCSH [www.schoolhealthny.com](http://www.schoolhealthny.com) – Forms | Notifications 12/16