INTERNATIONAL SCHOOL OF LATVIA

SEIZURE DISORDER
QUESTIONNAIRE & SCHOOL ACTION PLAN

Student Name: _____ Grade _____

Type of Seizure Disorder: *(please circle which type)*

- Partial Seizures – simple or complex
- Generalized Seizures – absence (petit mal) or tonic clonic (grand mal)

How often does your child get seizures? _____

Date of last seizure _____

Has you child ever had "status epilepticus"? If yes, when? _____

Current Daily Medications:

Name of Medication	**Dosage**	**How often**	**At home, At school***

Triggers: Please identify any things that may trigger a seizure:

[ ] Sleep deprivation
[ ] Physical activity or exercise
[ ] Nutritional deficiencies
[ ] Stress
[ ] Change in medications
[ ] Dehydration
[ ] Fever or illness
[ ] Other _____

Warnings or "auras": Please identify any warning signs your child experiences prior to a seizure:

[ ] *Sensory* - strange feeling, tingling sensation, or _____
[ ] *Emotional* - stress, fear, panic or _____
[ ] *Physical* - dizziness, headache, lightheadedness, nausea, blurred vision or _____
[ ] No warning signs

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SEIZURE ACTION PLAN

IF WE SEE THIS…	**We WILL DO THIS….**
Student is witnessed having a convulsive seizure	1. Guide student to the floor 2. Protect his/her head 3. Get Nurse 4. Call parent/guardian; and/or 5. Call ambulance (if needed) 6. Remain with student until ambulance arrives
Student becomes unconscious	1. Start CPR 2. Call ambulance 3. Call parent/guardian

Preferred local hospital: _____

) I authorize school personnel to implement this management and emergency plan as described above.

_____ _____

Parent/Guardian's Signature Date

If no, please provide separate instructions _____

_____

_____

_____

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