

HISTORY FORM FOR STUDENT WITH SEIZURES

Parent/guardian: Please complete the questions below. This information is very important for the school nurse as plans for your child's special needs are made. If you have any questions about this form, please talk with the school nurse.

CONTACT INFORMATION:

Student's name: _____ DOB: _____ Age: _____
 Address: _____
 School: _____ Grade: _____ Teacher: _____
 Parent/Guardian: _____ Home: _____ Work: _____ Cell: _____
 Other emergency contact: _____ Home: _____ Work: _____ Cell: _____
 Primary Care Provider: _____ Office: _____ Fax: _____ Emergency: _____
 Neurologist: _____ Office: _____ Fax: _____ Emergency: _____

MEDICAL INFORMATION:

Please list any allergies that your child has: _____

Please list any other medical problems that your child has: _____

Please list any medicines that your child takes (even if they are not given at school):

Medicine	What is medicine for?	Possible side effects to watch for
1.		
2.		
3.		
4.		
5.		

Does your child need to take any medicines at school? Yes No
 If yes, please complete a School Medication Administration form.

SPECIAL CONSIDERATIONS AND SAFETY PRECAUTIONS (Check all that apply to your child and describe how they impact your child.)

- | | |
|--|--|
| <input type="checkbox"/> General health: _____ | <input type="checkbox"/> Gym/sports: _____ |
| <input type="checkbox"/> Physical functioning: _____ | <input type="checkbox"/> Recess: _____ |
| <input type="checkbox"/> Learning: _____ | <input type="checkbox"/> Field trips: _____ |
| <input type="checkbox"/> Behavior: _____ | <input type="checkbox"/> Bus transportation: _____ |
| <input type="checkbox"/> Mood/coping: _____ | <input type="checkbox"/> Other: _____ |

May we share this information with your child's teacher? Yes No

Parent/Guardian Signature: _____ Date: _____

UPDATES TO HISTORY FORM

Date updated: _____

Update: _____

Parent/Guardian Signature: _____ Date: _____