

## HISTORY FORM FOR STUDENT WITH SEIZURES

**Parent/guardian:** 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: \_\_\_\_\_

Date updated: \_\_\_\_\_  
 Update: \_\_\_\_\_  
 \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_