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| --- | --- |
| SAMPLE:  INSERT LOGO/SAU/SCHOOL NAME | Seizure Interview  SCHOOL YEAR \_\_\_\_\_\_ |

|  |  |  |  |
| --- | --- | --- | --- |
| **Student**  Date of Birth Grade | Parent/Guardian Phone  Parent/Guardian Phone  Emergency Phone | | |
| Neurologist  Phone Last visit |
|  | * Maine Care | * Private Insurance | * Need Information |

After-school activities:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Diagnosis/Seizure type | Age of onset | Frequency | Duration of seizure | |
| Known Triggers: | | Describe seizure activity: | | |
| Does your child have a history of a seizure lasting longer than 5 minutes? | | | Does your child have a history of rescue medication use? | |
| Describe how your child feels/acts before a seizure. | | | If your child has a vagus nerve stimulator, please provide instructions: | |
| Describe how your child acts after a seizure. | | | Describe your child’s understanding of seizures. | |

Please be sure to list daily and emergency medications on the Annual Health Form.

Describe considerations necessary for the school day.

|  |  |
| --- | --- |
| * Athletics/Physical Education * Recess | * Classroom * Bus/Transportation |

Please share any health-related goals and needed assistance.

By signing below, I permit the school nurse to share information about my student’s health with appropriate school and medical personnel for my student’s ongoing safety at school.

Parent/Gaurdian\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*In an emergency when assistance is needed and emergency contacts are not reached, the healthcare provider will be contacted and if necessary 911 (emergency services) will be called.*