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

|  |  |
| --- | --- |
| **Student**Date of Birth Grade | Parent/Guardian PhoneParent/Guardian PhoneEmergency Phone |
| NeurologistPhone 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.*