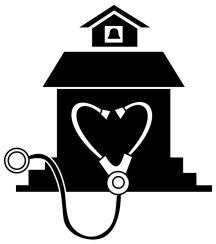
HUMBLE INDEPENDENT SCHOOL DISTRICT
HEALTH SERVICES



Seizure Health History/Assessment Form

Date:_____
Campus:_____

Student Name:_____ Student ID:_____ Date of Birth:_____
Parent/Guardian:_____Home Phone:_____
Work Phone:_____ Cell Phone:_____
Physician:_____ Phone:_____

1. Does your child have a diagnosis of seizures from a healthcare provider: ☐ **No** ☐ **Yes**

2. History of Current Status

a. Are there triggers for your child's seizures? ___yes ____no
If so, explain: _____
_____
_____

b. What type of seizures does your child have? _____
_____

c. Please list all medications your child takes: _____
_____
_____
_____

d. Age of student when seizures first began:_____

e. How often does your child have a seizure?
_____
_____
_____

f. Describe past seizure(s):_____
_____
_____
_____

g. Over time, are the seizures: ☐Same ☐Better ☐Worse

3. Symptoms

a. What are the early signs and symptoms of your student's seizure? *(Be specific; include things the* student *might do.)*_____
_____

b. How does your child communicate his/her symptoms?_____

c. How long do the seizures usually last: _____secs. _____mins.

d. Please check the symptoms that your child has experienced in the past:

Skin	**Mouth**	**Limbs**	**Throat/Face**	**Lungs**	**Heart**
☐ Pale	☐ Twitching	☐ Jerking	☐ Choking	☐ Difficulty breathing	☐ Weak pulse
☐ Flushing	☐ Pulls to side	☐ Stiffening	☐ Staring	☐ Stops breathing	☐ Loss of Consciousness
☐ Lips turn blue		☐ Flailing	☐ Blank Look		
☐		☐ Drop/Atonic	☐ Unresponsive to Commands		
☐					

4. Treatment

a. How have past seizures been treated?_____
b. What was the student's response to treatment?_____
c. Was there an emergency room visit? ☐ No ☐ Yes, explain:_____
d. Was the student admitted to the hospital? ☐ No ☐ Yes, explain:_____
e. What emergency treatment or medication has your healthcare provider recommended for use in a seizure?_____
_____
f. Has your healthcare provider provided you with a prescription for this medication? ☐ No ☐ Yes
g. Have you ever used the emergency treatment or medication? ☐ No ☐ Yes

h. Please describe any side effects or problems your child had in using the suggested treatment:_____

_____

5. Family/Home

a. How do you feel that the whole family is coping with your student's seizure disorder? _____

_____

b. Do you or your child carry emergency medicine in the event of a seizure? ☐ No ☐ Yes

c. Has your child ever needed the emergency medicine away from home? ☐ No ☐ Yes

d. Do you feel that your child needs assistance in coping with his/her seizure disorder?_____

6. General Health

a. How is your child's general health other than having a seizure disorder?_____

b. Does your child have other health conditions? _____

c. Has your child ever been hospitalized for any reason?_____

d. Please add anything else you would like the school to know about your child's health:_____

_____

7. Notes:

_____

Parent/Guardian Signature:_____ **Date:**_____

Reviewed by:_____ **Date:** _____