Health Services Department
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Linda Brennick, RN Head Nurse
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SEIZURE QUESTIONNAIRE

STUDENT_____ DOB: _____

Dear Parent or Guardian:
Previously received information indicates that your son/daughter has had history of seizure(s). Please complete the following to assist us to be better prepared in the event of a problem while at school. Thank you for your assistance.

What type(s) of seizures have been noted in the past?_____

Was any cause ever determined?_____ If yes, what?_____

How old was he/she when the first seizure occurred? _____

When was the most recent seizure? _____

How frequently do seizures occur? _____

How long do they generally last? _____

Please describe the seizures_____

How is the student immediately after a seizure? _____

Does he/she have an aura (warning) prior to a seizure? _____ If yes, what? _____

Has treatment at a hospital ever been required?_____

Name of Physician: _____Tel. # _____

MEDICATIONS CURRENTLY ORDERED (Please Print)

Medication	Dosage	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Name of Physician _____ Tel. # _____

IF YOUR PHYSICIAN RECOMMENDS THAT MEDICATION BE AVAILABLE AT SCHOOL, THE FOLLOWING IS REQUIRED:

- A note with specific instructions from the physician
- A note of authorization from the parent
- Properly labeled container(s) of the medication brought to the Health Office with the above notes
- All medication notes must be renewed annually


PINKERTON
ACADEMY
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