Coatesville Area School District
Parent/Guardian Questionnaire for Students with Seizures

Student Name_____School_____

School Year _____ Grade _____ Date _____

Dear Parent/Guardian,

You noted on the emergency card that your child has seizures. In order to give the appropriate care, we request that you complete this form and return it to the school nurse immediately. This information will be used to develop an individual action plan for your child.

If there is any change in this information during the school year, please notify the school nurse in writing.

Thank you,

Certified School Nurse

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1. Symptoms that student experiences prior to seizure events:
   _____
   _____
   _____

2. Frequency of seizures: _____
   Date of last seizure: _____Length of time: _____

Type of seizure: _____

Description of seizure: _____
_____

5. Special Instructions: _____
   _____

6. Medications needed:

Name _____
Dose _____ Time:_____

Name of Physician _____ Phone Number _____

I understand the above information will be used in an emergency action plan for my child. I give my permission to share this plan with my child's assigned teachers and appropriate personnel.
Signature of Parent/Guardian_____ Date_____