



SAHUARITA UNIFIED SCHOOL DISTRICT #30

SAHUARITA HIGH SCHOOL
SAHUARITA MIDDLE SCHOOL
SAHUARITA PRIMARY SCHOOL
ANZA TRAIL SCHOOL

WALDEN GROVE HIGH SCHOOL
SAHUARITA INTERMEDIATE SCHOOL
SOPORI ELEMENTARY SCHOOL
COPPER VIEW ELEMENTARY SCHOOL

EARLY CHILDHOOD CENTER



SCHOOL HEALTH SERVICES

Parent Seizure Information Letter

To the parent of _____

Date: _____

While reviewing the Student Health History Form you completed for your child, it was noted you indicate he/she may have Seizures.

In order to provide better health care services for your child in school, we need to know if this is currently an issue, and if your child requires special care and/or observation for this condition at school.

Please complete the section below and return to me at school, with appropriate documentation as requested. If you have any questions or concerns please feel free to contact me at any time. All medical information is confidential and will be shared only with teaching staff working directly with your child.

Thank you.

School Health Staff

Please check the box next to the most appropriate statement for your child, sign the bottom of this page and return to the school health office.

- ☐ This is no longer a health concern.
☐ My child DOES have Seizures:
• Prepare your child. Discuss the seizure plan, and how to handle symptoms.
• Keep school staff up-to-date on any changes in your child's care.
• PLEASE PROVIDE THE FOLLOWING DOCUMENTS ANNUALLY TO THE SCHOOL HEALTH OFFICE:
☑ Parent Seizure Questionnaire completed by parent/guardian
☑ Seizure Medical Management Plan for School Form signed by a Licensed HealthCare Provider and parent/guardian.
☑ Please see school health staff if your child requires medications to be given at school.

Name of Parent and/or Guardian

Signature

Date



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SCHOOL HEALTH SERVICES

Seizure Medical Management Plan for School

Valid for 1 school year. To be completed and signed ANNUALLY by licensed Primary Care Provider/Physician

Student's Name: D.O.B: Teacher:

SEIZURE INFORMATION

Table with 4 columns: Seizure Type, Length, Frequency, Description

Seizure Triggers or Warning Signs:
Student's Reaction to Seizure:

BASIC FIRST AID: Care and Comfort (describe basic first aid procedure):

Does student need to leave the room after a seizure? YES NO
If yes, describe the process for returning student to classroom

EMERGENCY RESPONSE

A "seizure emergency" for this student is defined as:

Seizure Emergency Protocol (check all that apply and clarify below):

- Contact School Health Office
Contact 911 for transport to:
Notify parent or emergency contact
Notify doctor
Administer emergency medications as indicated below
Other

Basic Seizure First Aid

- Stay calm & track time
Keep child safe
Do not restrain
Do not put anything in mouth
Stay with child until fully conscious
Record seizure on seizure observation record
For tonic-clonic (grand mal) seizure
Protect head
Keep airway open/watch breathing
Turn child on side

A seizure is generally considered an emergency when:

- A convulsive (tonic-clonic) seizure lasts longer than 5 minutes
Student has repeated seizures without regaining consciousness
Student has a first time seizure
Student is injured or has diabetes
Student has breathing difficulties
Student has seizure in water.

TREATMENT PROTOCOL DURING SCHOOL HOURS (include daily and emergency medications)

Table with 3 columns: Daily Medications, Dosage and Time of Day Given, Common Side Effects and Special Instructions

Emergency/Rescue Medication:

Does student have a VAGUS nerve stimulator? YES NO If yes, describe magnet use

Physician's Name

Phone Number:

Physician's Signature

Date:

(Required)

Parent/Guardian's Name:

Phone Number:

Parent/Guardian's Signature

Date:



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SCHOOL HEALTH SERVICES

PARENT SEIZURE QUESTIONNAIRE Pg 1/2

Valid for 1 School Year (Update Annually)

Please complete all questions. This information is essential for the school nurse and school staff in determining your student's special needs and providing a positive and supportive learning environment. If you have any questions about how to complete this form, please contact your child's school nurse.

CONTACT INFORMATION:

Student's Name: School Year: Date of Birth:
School: Grade: Classroom:
Parent/Guardian Name: Tel. (H): (W): (C):
Other Emergency Contact: Tel. (H): (W): (C):
Child's Neurologist: Tel: Location:
Child's Primary Care Dr.: Tel: Location:

Significant medical history or conditions:

SEIZURE INFORMATION:

1. When was your child diagnosed with seizures or epilepsy?

2. Seizure type(s):

Table with 4 columns: Seizure Type, Length, Frequency, Description

3. What might trigger a seizure in your child?

4. Are there any warnings and/or behavior changes before the seizure occurs? YES NO
If YES, please explain:

5. When was your child's last seizure?

6. Has there been any recent change in your child's seizure patterns? YES NO
If YES, please explain:

7. How does your child react after a seizure is over?

8. How do other illnesses affect your child's seizure control?

BASIC FIRST AID: Care and Comfort Measures

9. What basic first aid procedures should be taken when your child has a seizure in school?

Blank lines for writing first aid procedures

10. Will your child need to leave the classroom after a seizure? YES NO
If YES, What process would you recommend for returning your child to classroom?

Blank lines for writing return process

Basic Seizure First Aid:
- Stay calm & track time
- Keep child safe
- Do not restrain
- Do not put anything in mouth
- Stay with child until fully conscious
- Record seizure in log
For tonic-clonic (grand mal) seizure:
- Protect head
- Keep airway open/watch breathing
- Turn child on side



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SCHOOL HEALTH SERVICES

PARENT SEIZURE QUESTIONNAIRE Pg 2/2

Valid for 1 School Year (Update Annually)

SEIZURE EMERGENCIES

11. Please describe what constitutes an emergency for your child? (Answer may require consultation with treating physician and school nurse.)

Blank lines for describing emergency

12. Has child ever been hospitalized for continuous seizures? YES NO
If YES, please explain:

- A Seizure is generally considered an Emergency when:
- A convulsive (tonic-clonic) seizure lasts longer than 5 minutes
- Student has repeated seizures without regaining consciousness
- Student has a first time seizure
- Student is injured or diabetic
- Student has breathing difficulties
- Student has a seizure in water

SEIZURE MEDICATION AND TREATMENT INFORMATION

13. What medication(s) does your child take?

Table with 5 columns: Medication, Date Started, Dosage, Frequency and time of day taken, Possible side effects

14. What emergency/rescue medications needed medications are prescribed for your child?

Table with 4 columns: Medication, Dosage, Administration Instructions (timing* & method**), What to do after administration:

* After 2nd or 3rd seizure, for cluster of seizure, etc. ** Orally, under tongue, rectally, etc.

15. What medication(s) will your child need to take during school hours?

16. Should any of these medications be administered in a special way? YES NO
If YES, please explain:

17. Should any particular reaction be watched for? YES NO
If YES, please explain:

18. What should be done when your child misses a dose?

19. Should the school have backup medication available to give your child for missed dose? YES NO

20. Do you wish to be called before backup medication is given for a missed dose?

21. Does your child have a Vagus Nerve Stimulator? YES NO
If YES, please describe instructions for appropriate magnet use:

SPECIAL CONSIDERATIONS & PRECAUTIONS

22. Check all that apply and describe any considerations or precautions that should be taken:

- General health:
Physical Functioning:
Learning:
Behavior:
Mood/Coping:
Other:
Physical education (gym)/sports:
Recess:
Field trips:
Bus transportation:

GENERAL COMMUNICATION ISSUES

23. What is the best way for us to communicate with you about your child's seizure(s)?

24. Can this information be shared with classroom teacher(s) and other appropriate school personnel? YES NO

Parent/Guardian Signature: Date: