Forest Lake Area Schools Child Care Program
943 9th Ave SW, Forest Lake, MN 55025
(651) 982-8365

Seizure Assessment Form

Student Name: ___________________________________ Grade: ______Date of Birth: _______________

SAC Site: _____________________________ Parent/Guardian: ___________________________________

Phone: (H) _______________________ (W) __________________________ (C) _______________________

Physician / Clinic: ____ Phone: ________________

Hospital Preference: ____

When was your child diagnosed with a seizure disorder or epilepsy? ___________________ Age: _______
Check the type(s) of seizures your child has had:
☐ Tonic-Clonic (Grand Mal)
☐ Absence (Petite Mal)
☐ Complex
☐ Simple
☐ Febrile (high fever)
☐ other (describe):____
When was your child last seizure? ____
How frequently does your child have seizures? ☐ daily ☐ weekly ☐ monthly ☐ other: _____________
____
How long does a typical seizure last? ☐ seconds ☐ minutes ☐ other (explain): _____________________
____
Has your child ever been treated for status epilepticus (seizure lasting 5 minutes or longer)?
☐ No ☐ Yes, when? ____
Has your child ever been hospitalized or needed an ambulance due to a seizure? ☐ No ☐ Yes, when?
____
Does your child experience any early warning signs/symptoms before a seizure? ☐ No ☐ Yes, describe:
____
If yes, does your child recognize the early warning signs/symptoms? ☐ No ☐ Yes
Check any triggers for your child's seizures:

☐ bright lights
☐ temperature changes
☐ loud noises
☐ fever
☐ hunger
☐ fatigue
☐ stress
☐ other: ____________________________________
____

Check your child's usual characteristics of a seizure:

☐ loss of consciousness
☐ falling down
☐ muscle stiffness
☐ rhythmic convulsions
☐ purposeless activity
☐ aimless wandering
☐ fluttering eyelids
☐ blank stare
☐ twitching / jerking of body parts
☐ repetitive acts / movements
☐ confusion
☐ loss of awareness (i.e. – unresponsive)
☐ loss of control (i.e. – bladder, bowel, drooling, etc)
☐ other: ____________________________________

____

How does your child act after a seizure: ____

____

Any specific cares or measures that should be taken after a seizure? _______________________________

____

Does your child take any medications for their seizures? ☐ No ☐ Yes, explain:

____

____

____

Will your child be taking any medication during SAC/Sonic? (please include any rescue medications that your child may need in case of a seizure) ☐ No ☐ Yes, explain:

____

____

____

(All medication that will be administered during SAC/Sonic hours must have a signed medication form or orders from the treating physician. All medication authorization forms must be signed and dated by a parent or guardian)

Does your child have any restrictions related to their seizures? ☐ No ☐ Yes, explain:________________

____

____

How do you want SAC/Sonic to handle this concern? ____

____

____

Are there any other health concerns? ☐ No ☐ Yes, explain: ___________________________________

____

____

____

Parent/Guardian signature: ____ Date: _____________

All health forms are good for one calendar year from the date they are signed and date.

If your child shows signs of a seizure, 911 will be called immediately.

01/14/2020