CHINO VALLEY
UNIFIED SCHOOL DISTRICT

13461 Ramona Avenue • Chino, CA 91710 • 909.628.1201 • www.chino.k12.ca.us
Student Achievement • Safe Schools • Positive School Climate • Humility • Civility • Service

BOARD OF EDUCATION: John Cervantes • Andrew Cruz • Jonathan E. Monroe • James Na • Sonja Shaw • SUPERINTENDENT: Norm Enfield, Ed.D.

Seizure Disorder Health History/Update (Completed by Parent/Guardian)

To the Parent/Guardian of _____ Grade _____

Home Room/Teacher _____School _____

According to the school records, your child has a seizure disorder. The school needs the following information in order to assist your child in case of a seizure. Immediate care may be of an emergency nature. Please complete the following information and return it to the School Nurse.

1. At what age did the first seizure occur? _____ Was it following a high fever? Yes _____ No _____
2. Was it in connection with an illness? Yes_____ No_____ If yes, please explain _____
3. Approximate date of last seizure _____
4. How frequently **does** your child have seizures? ☐ Daily ☐ Other _____
5. Does the student experience an Aura? Yes _____ No _____ Describe Aura _____
6. Describe the triggers that may bring on seizures: ☐ Too much screen time ☐ Flashing lights ☐ Stress ☐ Exhaustion ☐ Other _____
7. Describe the seizure: □ General convulsions □ Repetitive movements ☐Staring/blank gaze ☐ Change of skin color (pale, blue) □ Loss of consciousness/fall to ground ☐ Labored breathing ☐Dilation of pupils ☐ Involuntary loss of urine or feces ☐ Other _____
8. Approximately how long does a seizure last? _____
9. Any recent change in seizure pattern? _____
10. Describe your child's behavior following the seizure _____
11. When was your child last seen by a physician for his/her seizure disorder? _____
12. Does your student take daily meds at home for seizures? ☐Yes ☐No

Date Began	Medication	Dosage	Freq/Time of Day	Route	Side Effects

13. Does your student have an emergency medication prescribed for seizures? Yes _____ No _____
    If yes, when was it last administered? _____

****Please fill have your physician fill out the physician authorizations form for emergency seizure medication

Date Began	Medication	Dosage	Instructions (Timing/Route)	Action after Administration

14. Does your student have a VNS? Yes_____ No_____. If yes, please have your physician fill out the physician authorization form for VNS.
15. Does your child ride the bus? ☐ Yes ☐No
16. Does your child participate in any after school activities? ☐ Yes ☐No. If yes, please describe:

_____

***Please have your physician fill out the seizure action plan. If a seizure action plan is not submitted, basic seizure first aid will be provided, which may include calling 911 for any seizure activity.

Print Parent/Guardian Name _____Signature _____
Contact Phone Number _____ Date _____

PLEASE RETURN THIS FORM TO THE SCHOOL NURSE