Assessment Form: Seizure Disorder

Easton Arts Academy
30 North 4th Street, Easton, Pennsylvania 18042
Phone (484) 546-4230 Fax (610) 829-6076

Student Name: ________________________________ Date: ___________________
School: ______________________________ Grade: ______ Teacher: _________
Parent/Guardian: __________________________ Daytime Phone: ____________________
Parent/Guardian: __________________________ Daytime Phone: ____________________

The following information will help the school nurse and staff determine your student's special needs. Please complete all questons. To provide additional information, please use the back of the form.

Nurse's name: _____________________________ School Phone: _____________________

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1. When did your student's seizures begin? ______________________________________
2. What happens during a seizure? Describe. ____________________________________
____
3. Has seizure activity changed from the past? In what ways? _____________________
____
4. What causes your student to have more seizure activity? (circle any applicable)
Illness Fever Asthma Meds Allergy Meds Other: ___________________
5. What medications does your student take now? How much? How often?
Medication: ______________________ How much: ______ How often: _______________
Medication: ______________________ How much: ______ How often: _______________
Medication: ______________________ How much: ______ How often: _______________
6. What do you do if your student misses a dose of medicine? ______________________
____
7. Please note if you student needs special accomodations for: (circle any applicable)
Physical education classes Recess Field Trips Other ____________________
8. When did you student last see the doctor who treats these problems? ____________
9. Please provide contact information for the doctor who treats your student.
Name: ____
Address: ____
City/State/Zip: ____________________ Phone: __________________

Parent/Guardian Signature: ________________________ Date: ____________________

School Nurse Office Use Only
Date Received: _____________________
Updated: __________________________
Updated: __________________________

cc: Student health file
Teacher file
Parent/Guardian
Physician
Case Manager (if applicable)

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