FLORIDA DEPARTMENT OF HEALTH IN MIAMI-DADE COUNTY
SCHOOL HEALTH PROGRAM
HEALTH HISTORY AND CONSENT-SEIZURE DISORDER

Student: ______________________________ **DOB**__________ **Teacher:** ____________ **Grade:** ________

School: __________**Parent/Guardian & Phone(s):** ____
Physician & Phone: ____ **School Year:** ______________
KNOWN ALLERGIES: ____

Dear Parent/Guardian:
School records or medical information indicates your child has seizure disorder. In order to attend to your child's health and safety, the school requires a health history. Please return this form to the nurse as soon as possible. It will become part of your child's confidential school health record.

____________________________ ____________________________ ________________
School Nurse Phone number Date

1. When was your child's last seizure? How often do they occur? ____
   When was the last time your child saw the doctor? ____
   Has your child ever been hospitalized for seizures? ☐ No ☐ Yes (When?) ______________________________
2. Check ☑ or list your child's triggers for seizures:
   ☐ Missed Medication ☐ Lack of Sleep ☐ Illness or fever ☐ Poor Nutrition ☐ Stress
   ☐ Bright Lights ☐ Menstrual Cycle ☐ Violent Movements/Fighting ☐ Other ______________________________
3. Please describe (AURA) any unusual behavior (if any) before a seizure occurs :______________________________
4. Describe your child's typical seizure activity. Please include usual seizure activity, duration, and part(s) of the body involved in the seizure:____
   ____
5. Please check ☑ the type of seizure disorder your child has:
   ☐ Simple Partial ☐ Complex Partial
   ☐ Generalized Tonic Clonic (Grand Mal) ☐ Absence (Usually less than 20 seconds) ☐ Unknown
6. Please list the medications your child takes for seizures:

Name of Medication	Dosage	Time

7. List any **other** medications your child takes?
   ____
   ____
8. **Self-Care**
   a. Is your child able to monitor their symptoms and report changes? No Yes
   b. Does your child:
      1. Know what medication to take No Yes
      2. Know what activity/dietary limitations No Yes
      3. Tell an adult immediately, if not feeling well No Yes
      4. Wear a medical alert bracelet, necklace, or watchband No Yes

CONSENT

Please circle your response and sign: I **do give the School Nurse my permission to share information relevant to my child's medical status with school staff on a "need to know" basis, if she/he determines that this information is necessary to assure my child's health and safety.**

PARENT/GUARDIAN SIGNATURE: ______________________________ **DATE:** ________________