



**Florida Department of Health in Miami-Dade  
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? \_\_\_\_\_
2. When was the last time your child saw the doctor? \_\_\_\_\_
3. Has your child ever been hospitalized for seizures?  No  Yes (When?) \_\_\_\_\_
4. 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 \_\_\_\_\_
5. Please describe (AURA) any unusual behavior (if any) before a seizure occurs  
 \_\_\_\_\_  
 \_\_\_\_\_
6. Describe your child's typical seizure activity. Please include usual seizure activity, duration, and part(s) of the body involved in the seizure:  
 \_\_\_\_\_  
 \_\_\_\_\_
7. Please check  the type of seizure disorder your child has:  
 Focal Onset Aware  Focal Onset Impaired Awareness  Generalized Tonic Clonic  Absence  
 Unknown
8. Please list the medications your child takes for seizures:  

Name of Medication	Dosage	Time
_____	_____	_____
_____	_____	_____

9. List any other medications your child takes.  
 \_\_\_\_\_  
 \_\_\_\_\_

10. 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 /do not** 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: \_\_\_\_\_