USD 320
Wamego Public Schools

1008 8th Street
Wamego, KS 66547
785-456-7643

Central Elementary
900 7th Street
Wamego, KS 66547
785-456-7271

West Elementary
1911 6th Street
Wamego, KS 66547
785-456-8883

Wamego Middle School
1701 Kaw Valley Road
Wamego, KS 66547
785-456-682

Wamego High School
801 Lincoln Street
Wamego, KS 66547
785-456-2214

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www.usd320.com

WAMEGO USD 320
Parent Interview Questionnaire for Seizure History

Child's Name_____ Birthdate_____ Age____ Grade_____

Teacher_____ Information provided by_____ Date_____

Please answer all questions. Attach additional pages if needed for explanation or more information.

Who does your child see for regular health visits? _____ Phone_____

Who does your child see for seizure management? _____ Phone _____

When was your child diagnosed with seizure disorder?_____ At age _____

Has your child been diagnosed with any other medical conditions? No____ Yes____ Please explain:_____

_____

_____

What symptoms does your child experience during a seizure? _____

_____

_____

Is your child aware of an aura (distortion of vision, hearing or smell) before a seizure? _____

What words would your child use to describe the *above* symptoms? _____

_____

Does your child lose consciousness during a seizure? No____ Yes____

How often does your child experience a seizure? _____ times/month; _____ times/day; other _____

_____

How long does your child's seizure typically last? _____

When was your child's last seizure? Date: _____ Time: _____ Duration: _____

Has your child experienced a seizure lasting longer than five minutes? No____ Yes____

Please explain: _____

_____

Has your child ever gone to the emergency room or been hospitalized for his/her seizures? No___ Yes____

Please explain: _____

_____

What events might trigger a seizure for your child? _____

What medications does your child take to manage his/her seizure disorder?

Name of Medication: _____ Amount:_____ When taken:_____

Has your child been instructed on when and how to take these medications independently? No____ Yes____

Are there any side effects from your child's medications that his/her teacher needs to be aware of?

No____ Yes____ Please explain:_____

_____

Is your child participating in sports or school sponsored extra-curricular activities? No____ Yes____

Please explain: _____

What are your child's feelings about having a seizure disorder? _____

_____

Is your child comfortable alerting others when experiencing symptoms of a possible seizure? No____ Yes____

Does your child wear a "medic alert" necklace/ bracelet? No____ Yes____

Describe your child's understanding of their seizure disorder? None /Limited___ Basic___ Knowledgeable____

Has your medical provider indicated in writing that your child needs special accommodations in school?

No____ Yes____ Please explain:_____

_____

Is there anything else you'd like us to know? _____

_____

_____

_____ _____

Parent/Guardian Signature Date

_____

Parent/Guardian Best Contact Number