Galloway Township Public Schools
101 South Reeds Road
Galloway, NJ 08201
(609) 748-1250
http://www.gtps.k12.nj.us

SEIZURE QUESTIONNAIRE

Dear Parent/Guardian:

You have informed the school nurse that your child has a seizure disorder. In cooperation with your child's physician, please complete the information below and return it to the school nurse. **This form is only valid for the current school year.**

Student's Name: _____ Grade: _____ Date of Birth: _____

MEDICAL HISTORY: (To be completed by parent/guardian and physician)

Briefly describe the type of seizure that the child experiences: _____
_____

What behaviors might occur before a seizure?
_____
_____

What kinds of behaviors are observed during a seizure? _____
_____

What was the date of the last seizure? _____

How often do the seizures occur? _____

How long do the seizures last? _____

EMERGENCY PHONE NUMBERS:

Mother: Home_____Work_____
Father: Home_____Work_____
Other: Name_____Relationship _____
Home_____Work _____
Preferred hospital_____

I understand that this information may be shared with appropriate staff members having contact with my child.

_____ _____
Parent's/Guardian's Signature Date

OVER>>>>>

"Where Children and Learning Come First"

Student's Name: _____ Grade: _____ Date of Birth: _____

PHYSICIAN PERMISSION TO ADMINISTER MEDICATON
TO BE COMPLETED BY PHYSICIAN

EMERGENCY PROCEDURES:
List the actions that are to be taken for this child if he/she experiences a seizure:
1. _____
2. _____
3. _____

MEDICATION ORDER:
Name of medication_____
Dosage _____ Route _____Time _____
Frequency _____Indications for use_____
Side effects _____
Duration of order _____
May withhold does for field trips (Teachers are not in attendance on field trips to administer medication and teachers are not permitted to administer medication): _____YES _____ NO
Parent/Guardian will accompany child on field trip to administer medication: _____YES _____NO

List other medications child is on which may enhance, alter or impact this medication _____
_____

_____ _____
Physician/Health Care Provider's Signature/Stamp Date

_____
Please Print Physician/Health Care Provider's Name, Address, and Phone Number

PARENT PERMISSION TO ADMINISTER MEDICATION

I request and grant permission for the school nurse to administer medication to my child, _____ as prescribed by his/her physician as indicated on the reverse side this form and as per the policy of the Galloway Township Board of Education and State law. I understand that medication is to be brought to school by myself in the original prescription bottle/box labeled properly by the physician or pharmacist.

_____ _____ _____
Parent's/Guardian's Signature Date Phone Number