School Year: _____

Model Laboratory School

SCHOOL HEALTH DIVISION
521 Lancaster Ave.
Richmond, KY 40475
Office: (859) 622-8575
Fax: (859) 622-6658

PARENT PACKET - SEIZURE

Dear Parent/Guardian:

You have informed us that your student has a medical concern. Enclosed are the forms, which need to be completed by both the Parent/Guardian and student's Physician. These forms are necessary in order for the School Nurse or appropriately trained school personnel to perform or administer specific medical treatment or procedures. This information will help us work with your student to minimize unnecessary restrictions, feelings of being treated differently, and possibly absenteeism.

Please send a current picture of your student in order for the student to be easily identified. This information will be distributed to appropriate school personnel on a need-to-know basis and may include bus drivers, substitute teachers, cafeteria staff, and others who work with your student daily.

To help your student, please let us know of any changes in your student's medical condition or emergency daytime phone numbers.

The following need to be returned to the School Nurse at your student's school:

- **Seizure Healthcare Plan**
- **MLS First Aid for Seizures**
- **Physician & Parent/Guardian Authorization for Diastat Medication Administration**

We are looking forward to a great year with your student!

Please call the School Health Services program at 622-8575 if you have any questions.

School Year: _____

SEIZURE HEALTHCARE PLAN

(This form will be made available to teachers and appropriate school staff.)

Student's Name: _____ DOB:___ / ___ / _____

Allergies: _____

School: _____ Teacher: _____ Grade: _____

Place Student's Picture Here

Parent/Guardian(s) Name(s): _____

Address/Zip Code: _____

Call Parent/Guardian 1: – Home: _____ Work: _____ Cell: _____

Call Parent/Guardian 2: – Home: _____ Work: _____ Cell: _____

ALTERNATE PERSON IN CASE OF EMERGENCY:

NAME: _____ RELATIONSHIP: _____ PHONE: _____

PHYSICIAN'S NAME: _____ PHONE: _____

HOSPITAL OF CHOICE: _____

SEIZURE HISTORY

WHAT TYPE(S) OF SEIZURE(S) DOES YOUR STUDENT HAVE? _____

_____

- DESCRIBE EACH TYPE OF SEIZURE: _____

  _____
- HOW OFTEN DO THEY OCCUR? _____

  _____
- DATE OF LAST SEIZURE: _____
- HOW LONG DO THEY LAST? _____

ANY WARNING SIGNS OR BEHAVIOR CHANGES PRIOR TO SEIZURE(S)? _____

_____

USUAL BEHAVIOR AFTER SEIZURE: _____

ANY SPECIAL ADAPTIVE OR SAFETY EQUIPMENT (I.E., HELMET) NEEDED? _____

_____

FOR SCHOOL NURSE ONLY:

STUDENT HAS DIASTAT ORDERED AND AVAILABLE AT SCHOOL? ☐ YES ☐ NO

LOCATION OF DIASTAT AT SCHOOL : _____

REVIEWED BY: _____ *RN* *DATE:* _____

School Year: _____

FIRST AID FOR SEIZURES

Parent/Guardian(s), below you will find the Madison County Public School First Aid procedure for Seizures. Please read it carefully and make any individual changes that apply to your student in the space provided.

SEIZURE - CONVULSIONS

SEIZURES MAY BE ANY OF THE FOLLOWING: •.Episodes of staring with loss of eye contact •.
Staring involving twitching of the arm or leg •.Generalized jerking movements of the arms or legs
•.Unusual behavior for that person (e.g. running, belligerence, making strange sounds, etc.)
•.If head injury is suspected, DO NOT MOVE THE CHILD
1..Immediately contact the School office/School Nurse
2..Note the time a seizure starts and the length of time it lasts
3..If student is off balance, place on the floor for observation and safety
4..Do NOT restrain movements
5..Move surrounding objects to avoid injury
6..Do NOT place anything in between the teeth or give anything by mouth
7.Keep airway clear by placing student on side and cushion head
8..Trained personnel should follow Emergency Action Plan and administer seizure medication prescribed by primary health care provider
9..Principal/Designee notifies parent/guardian

CALL 622-1111 if: •.Prolonged seizure lasting more than 5 minutes or as specified in Emergency Action Plan
•.Student has seizures following one another at short intervals

•.Difficulty breathing after a seizure

•.Pregnancy or any signs of injury
•.Repeated seizures in the same day

•.A first time seizure

NEVER LEAVE STUDENT ALONE

SEIZURE MEDICATION TAKEN AT HOME

STUDENT NAME: _____ DOB: _____ SCHOOL: _____

ALLERGIES: _____

Medication: _____ **Medication: _____**

Dosage / Time: _____ **Dosage / Time: _____**

Possible side effects: _____ **Possible side effects: _____**

* **Any medications to be given at school must be authorized by Parent/Guardian and Physician on official forms according to Madison County Board of Education Policy. Forms may be obtained from school office staff. Medication should be administered at home if at all possible.**

Other information or instructions: _____

_____

Signature of person completing form: _____

Relationship: _____ **Date: _____ / _____ / _____**

****

Reviewed by: _____, RN **Date: _____ / _____ / _____**

School Year: _____

PHYSICIAN AND PARENT/GUARDIAN AUTHORIZATION FOR DIASTAT MEDICATION ADMINISTRATION

The Board of Education of Madison *County has adopted a procedure wherein a member of the staff of the school the student is attending will administer either an injection or prescribed drug in the event of a crisis. The undersigned understands that the staff member administering the above care is not a trained health professional, but is trained by the School Nurse per state law and that this individual will undertake to do his or her best to comply with the recommended procedure as developed by the student's Physician in the case of a life-threatening emergency wherein immediate intervention is required by school personnel.*

The undersigned Parent/Guardian does hereby consent to the intervention of school personnel in accordance with the instructions contained in the attached form from the student's Physician. Additionally, the undersigned agrees to hold school personnel harmless for any injuries resulting from the emergency care unless the injury was caused by school personnel's negligence.

PHYSICIAN ORDER FOR EMERGENCY ACTION PLAN

To be completed by the student's Physician and returned to School Health: Confidential FAX (859) 622-6658 *or by mail:* Model Laboratory School, 521 Lancaster Ave., Richmond, KY 40475.

STUDENT'S NAME: _____ **DOB:** _____

ALLERGIES: _____

DIAGNOSIS: _____

SIGNS AND SYMPTOMS WHEN MEDICATION IS NEEDED: _____

_____

DRUG ORDERED, DOSAGE AND ROUTE OF ADMINISTRATION:

_____
Medication/Dose/Route

- **Per protocol, Rescue Squad (622-1111) will be contacted if Diastat is used, unless Physician's order states otherwise.**
- **Notify Parent/Guardian or Emergency Contact.**

Comments: _____

_____

X _____ _____
(Physician's Signature) Date

_____ _____
(Physician's Name - Printed) Telephone Number

**** PLEASE NOTE: The School Nurse is NOT always in the school building and trains non-medical staff to administer medication. See above and below.***

PARENT/GUARDIAN STATEMENT

☐ I, the undersigned Parent/Guardian of the student named above, **request that a *trained staff member administer the above medication** to the student per Physician instructions. I agree to furnish the necessary prescribed medication and agree to notify the School Nurse immediately of any changes. I understand the Madison County Board of Education Medication Policies & Procedures (09.2241) are readily available for me to read. I sign this voluntarily and with full knowledge of its significance. I agree to pick up any unused medication within two weeks of the last day of school, or it shall be destroyed.

****Parent/Student are responsible to have medication available at school.***

Parent/Guardian Signature:_____ **Date: _____ / _____ / _____**

Home Phone: _____ **Work: _____** **Cell: _____**

REVIEWED BY: _____ *RN Date:* _____

Madison County School District School Health Program

Permission Form for Prescribed and Over the Counter Medication

TO BE COMPLETED BY SCHOOL PERSONNEL

School:_____Date form received:_____

I/we acknowledge receipt of this Physician's Statement and Parent Authorization._____

Student Name:_____Student age: _____Date of Birth:_____

Grade:_____Homeroom/Classroom:_____

TO BE COMPLETED BY PARENT / GUARDIAN

************(MUST BE IN CHILD SPECIFIC, CURRENT, ORIGINAL PHARMACY LABELED CONTAINER)************

Name of medication: _____**Reason for medication:**_____

ALLERGIES:_____ **Any OTHER Condition(s):**_____

Form of medication/treatment:_____

☐ Tablet/capsule ☐ Liquid ☐ Inhaler ☐ Injection ☐ Nebulizer ☐ Other _____

Instructions (Schedule and dose to be given at school:_____

_____

Start: ☐ Date form received ☐ Other, as specified:_____

Stop: ☐ End of school year ☐ Other date/duration:_____

☐ **For episodic/emergency events only**

Restrictions and/or important side effects: ☐ No restrictions

☐ Yes. Please describe:_____

_____

Special storage requirements: ☐ None ☐ Refrigerate

Other Instrructions:_____

Parent or Guardian Signature_____Date:_____

Health Care Provider Name_____

Address:_____ Phone:_____ FAX:_____

I give permission for (name of child)_____ is to receive the above stated medication at school according to standard school policy. I release the School Board and its employees from any claims or liability connected with its reliance on this permission.

(Parent/guardians to bring the medication in its original container.)

Date:_____**Signature:**_____ **Relationship:**_____

Home phone:_____ **Work phone:**_____ **Emergency or CELL phone:**_____

TO BE COMPLETED BY Health Care Provider

♦♦♦For Self-Administration or EMERGENCY ♦♦♦For Self-Administration or EMERGENCY ♦♦♦For Self-Administration or EMERGENCY♦♦♦

This student is capable, responsible, and demonstrated self-administration of the above medication:

☐ **Yes - Unsupervised** ☐ **Yes-Supervised** ☐ **No**

This student may carry this medication: ☐ **Yes** ☐ **No** **Any restriction(s):**_____

The school nurse will delegate and train designated school personnel to give the above stated emergency medication if necessary.

Please indicate if you have provided additional information:

☐ On the back side of this form ☐ As an attachment

Signature:_____Date_____

Physician or Authorized Provider

******Over the counter medications can be given no more than 3 consecutive days without written orders from health care provider.** **MCBE 1 (7-2014)**

Adapted from the Academy of Pediatrics