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 the student's Physician. These forms are necessary in order for the school Nurse or apppropriately 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, fellings of being treated differently, and possibly absenteeism.

Please send a **current** picture of your student in order for the stuednt 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:

1. **Seizure Healthcare Plan**
2. **MLS First Aid for Seizures**
3. **Physician & Parent/Guardian Authorization for Diastat Medication Admnistration**

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

Please call the School Health Clinic at (859) 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: ________

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

Address/Zip Code: ____

Doctor: ______________________ Phone: ______________ Hospital of Choice: ____________

Parent/Guardian 1: *Home:* _______________ *Work:* ________________ *Cell:* __________________

Parent/Guardian 2: *Home:* _______________ *Work:* ________________ *Cell:* __________________

Or call Emergency Contact if unable to reach Parent/Guardian:

Name: _____________________ *Phone:* ______________________ *Relation:* ______________

SEIZURE HISTORY

1. What type of seizures does your student have? ___________________________________
   ____
   - Describe each type of seizure: ____
     ____
   - How often do they occur? ____
     ____
   - Date of last seizure: ____
   - How long do they last? ____
2. Any warning signs or behavior changes prior to seizure(s)? ________________________
   ____
3. Usual behavior after seizure: ____
4. 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: ____________

Revised 6/4/2020

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 (i.e. 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 movement.
  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 THE 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 Model Laboratory Schools at Eastern Kentucky University Policy. Forms may be obtained from school office staff. Medication should be administered at home if 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

Model Laboratory Schools at Eastern Kentucky University 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 the School Health Clinic: 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: ____________________________________

____

- **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: ____

____

____ ___________________________

(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 Model Laboratory Schools at Eastern Kentucky University Policies and Procedures (09.224 AP.1) 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:* ___________________

School Year: __________