INDIVIDUAL HEALTH PLAN/EMERGENCY CARE PLAN FOR STUDENT WITH SEIZURES

TO BE RENEWED EACH SCHOOL YEAR

Student Name_____ Birth Date _____

School _____ Grade_____ Teacher_____School Year _____

According to our records, your student has a history of seizures. Completion of this form will keep your student's health record current.

1. My student has seizures:
   YES **Complete the form, sign, date, and return it to your student's school**.
   NO **Skip to the end of this form, sign, date, and return to your student's school.**
2. Check the type of seizure your student has:
   Generalized tonic-clonic: Muscles become rigid with convulsive movements and impaired consciousness
   Complex partial: (focal impaired awareness): May consist of purposeless activity and blank stare
   Simple partial: (focal aware): Jerking of one limb or side of body, consciousness maintained
   Absence: Brief interruption of consciousness often characterized by an appearance of daydreaming
3. List any known seizure triggers:_____
4. Describe any warnings and/or behavior changes before the seizure:_____
   _____
5. Any recent changes in your student's seizure patterns: Yes No
   If yes, explain: _____
6. Describe what happens during the seizure:_____
   _____
7. Describe what happens after the seizure: _____
   _____
8. How long does seizure last? _____
9. Approximate date of last seizure: _____
10. How frequent are seizures? daily weekly monthly yearly
11. Medication your student takes at home for seizures: _____
12. Will your student need any treatment or medication at school for seizures? Yes No
    If yes, explain: _____

If medication is needed at school, please complete the
"Consent Form For Administration of Emergency Seizure Medication During the School Day"

13. Health Care Provider Name: _____ Phone # _____
    Clinic:_____ Fax # _____
14. Are there any special considerations or precautions regarding school activities and field trips? Yes No If yes, explain: _____
15. Contact parent/guardian or alternative contact person (*List in order of who to call first):*
    Name: _____Relationship: _____ Phone#_____
    Name: _____Relationship: _____ Phone#_____
    Name: _____Relationship: _____ Phone#_____

SCHOOL ACTION/EMERGENCY PLAN

If student has a seizure while at school, staff will do the following:

- Stay with student
- Protect student and provide privacy
- Note the time the seizure begins and ends
- Place barrier between self and body fluids
- Notify health office and contact parent/guardian
- Record seizure on observation form

911 will be called if ANY of the following occur: *(Notify office and parent when 911 is called)*

- Seizure lasting longer than ___minutes (*Follow insturctions from HCP).*
- Pale/gray/bluish color around mouth and nail beds blue or dusty.
- Obstruction of airway or no breathing.
- No pulse.
- First time seizure - student does not have a history of seizures.
- Multiple seizures or doesn't recover (wake) between seizures.
- Student becomes injured during the seizure.
- If seizure happens in water.

PARENT / GUARDIAN AUTHORIZATION

1. I understand that this plan may be shared with all school staff working directly with my student.
2. I will contact the School Nurse/designee if a change in the current plan is indicated.
3. I authorize the School Nurse/designee and health care provider to exchange information related to my student's seizure plan and medication.
4. I understand if my student rides the school bus and/or participates in before or after school activities, it is my responsibility to inform the staff/bus company of my student's seizure condition and health plan.

PARENT/GUARDIAN SIGNATURE :_____ **Date** : _____

SCHOOL NURSE:_____**Date** _____

CONSENT FORM FOR ADMINISTRATION OF EMERGENCY SEIZURE MEDICATION DURING SCHOOL DAY

TO BE RENEWED EACH SCHOOL YEAR

Before medication can be administered by school personnel this form must be completed and on file with the school health office

Student Name _____ Birth Date _____

School _____ Grade _____ Teacher _____ School Year _____

PHYSICIAN / LICENSED PRESCRIBER ORDER

Medication: _____ **Route:** _____

Dosing and Administration of Emergency Seizure Medication:

Administer _____ mg of medication after seizure of _____ minutes duration, or if _____ (indicate number) seizures occur within _____ (indicate period of time).

Criteria for repeat dosing: _____

Other instructions:_____

_____

Possible side effects: _____

Emergency Seizure Medication should be administered for the following type(s) of seizure(s):

_____Generalized tonic-clonic (please describe): _____

_____Other (please describe): _____

_____

PHYSICIAN/LICENSED PRESCRIBER SIGNATURE: _____ DATE:_____

PRINT PRESCRIBERS NAME:_____ PHONE #:_____

CLINIC:_____ FAX #: _____

PARENT/GUARDIAN AUTHORIZATION

1. I request the above medication be given to my student during regular school hours by designated personnel as delegated, trained, and supervised by the School Nurse and ordered by the physician/licensed prescriber.
2. I will provide this medication in the original, properly labeled pharmacy container.
3. I authorize the School Nurse/designee to exchange information with my student's healthcare provider concerning any questions that arise with regard to the listed medication, medical condition, emergency plan, or side effects of this medication.
4. I authorize the School Nurse/designee to communicate with appropriate school personnel regarding this medication and emergency care plan for my student.
5. I release school personnel from any liability in relation to the administration of this medication at school.
6. I will contact the School Nurse/designee if a change in the current medication is indicated.
7. Field Trips - I give permission for the trained school personnel to administer the medication on a field trip.
8. I have read and understand the Medication Guidelines included with this form.

Parent/Guardian Signature:_____ Date:_____

School Nurse Signature:_____Date:_____

MEDICATION GUIDELINES

The administration of medication to students shall be done only in exceptional circumstances where the student's health may be jeopardized without it. Whenever possible, administration of medication should be done at home. Medication prescribed three times per day can be given before school, after school, and bedtime. **If a new medication is started, the first dose must be given at home, unless it is a rescue medication.**

1. Administration of prescription and non-prescription medication by school personnel must only be done according to the written order of a physician/licensed prescriber and written authorization of parent/guardian and School Nurse, regardless of the student's age.

    a. Mixed dosages in a single container will not be accepted for administration at school.
    b. If a half tablet is required for a correct dosage, it is the parent/guardian's responsibility to provide pre-cut tablets for administration at school.
    c. Altered forms of medication will not be accepted or administered at school.
    d. Narcotics/medical cannabis will not be administered at school.
    e. Aspirin-containing products will not be administered at school.
    f. Only FDA approved treatments will be provided at school.

2. **All medication (prescription and non-prescription) must be brought to and from school by a parent/guardian in its original container.** The following information must be on the prescribed container label:
    a. Students full name
    b. Name and dosage of medication
    c. Time and directions for administration at school
    d. Physician/licensed prescriber's name
    e. Date (must be current)

3. New consent forms with licensed health care provider and parent/guardian signatures must be received each school year.

4. A new medication consent form is required when the medication dosage or time of administration is changed.

5. When a long term daily medication is stopped, a written physician/licensed prescriber's order is requested.

6. Medication will be kept in a locked cabinet in the health office unless authorized by the School Nurse, and must not be carried by the student.

7. Students with severe allergies who need their epinephrine auto-injector during the school day will be allowed to self-manage, carry, and be responsible for the administration of their epinephrine auto-injector with written consent of their physician/licensed prescriber and parent/guardian and in agreement with the School Nurse.

8. Students with asthma who need to use their inhaler during the school day will be allowed to self-manage, carry, and be responsible for the administration of their inhaler with written consent of their physician/licensed prescriber and parent/guardian and in agreement with the School Nurse.

9. Secondary students may carry and use **non-prescription** medication with written consent of their physician/licensed prescriber, parent/guardian, signature of student agreement, and with the consent of the School Nurse. This applies to all secondary students, regardless of age. This medication cannot contain ephedrine, pseudoephedrine, aspirin or medical cannabis. Special arrangements must be made with the Licensed School Nurse concerning administration of medication to students through gastrostomy tubes, rectal or injectable routes.