INDIVIDUAL HEALTH PLAN/EMERGENCY CARE PLAN FOR STUDENT WITH SEIZURES

TO BE RENEWED EACH SCHOOL YEAR

(If you need assistance completing this form, contact the Licensed School Nurse)

Student Name_____ Birth Date _____

School _____ Grade_____ Teacher_____ School Year _____

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

1. **My child has seizures.** ☐ YES **Complete form, sign and date back, and return it to your child's school.**
   ☐ NO ***Parent/Guardian Signature:** _____ **Date:** _____
   (IF "NO" IS CHECKED, DO NOT FILL OUT THE REMAINDER OF THE FORM, BUT SIGN AND RETURN IT TO YOUR CHILD'S SCHOOL.)
2. Check the type of seizure your child 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 child'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 child takes at home for seizures: _____
12. Will your child need any treatment or medication at school for seizures: ☐ Yes ☐ No
    If yes, explain: _____

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

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

-OVER-

Student Name _____

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 lasts more than **three** minutes (unless otherwise indicated by health care provider).
- Student has difficulty breathing
- Student aspirates
- Student becomes injured during seizure or seizure occurs in the water
- Student has repeated seizures without regaining consciousness

PARENT / GUARDIAN AUTHORIZATION

1. I understand that this plan may be shared with all school staff working directly with my child.
2. I will contact the Licensed School Nurse/designee if a change in the current plan is indicated.
3. I authorize the Licensed School Nurse/designee and health care provider to exchange information related to my child's seizure plan and medication.
4. **I understand if my child 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 child's seizure condition and health plan.**
5. *By typing my name on the line below I understand and acknowledge that electronically signed documents will be valid and enforced in the same manner as a hand-signed document and that a record or signature will not be denied legal effect or enforceability under law solely because it is an electronic form.*

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

LICENSED SCHOOL NURSE _____Date:_____

CONSENT FORM FOR ADMINISTRATION OF EMERGENCY SEIZURE MEDICATION DURING SCHOOL DAY

TO BE RENEWED EACH SCHOOL YEAR

(If you need assistance completing this form, contact the LIcensed School Nurse)

****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 ________

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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 NAME:____ PHONE #:____________

CLINIC:____ FAX #: ______________

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PARENT/GUARDIAN AUTHORIZATION

1. I request the above medication be given to my child during regular school hours as ordered by the physician/licensed prescriber.
2. I give permission for the medication to be given by designated personnel as delegated, trained, and supervised by the Licensed School Nurse.
3. **I will provide this medication in the original, properly labeled pharmacy container.**
4. I authorize the Licensed School Nurse/designee to exchange information with my child's healthcare provider concerning any questions that arise with regard to the listed medication, medical condition, emergency plan, or side effects of this medication.
5. I authorize the Licensed School Nurse/designee to communicate with appropriate school personnel regarding this medication and emergency care plan for my child.
6. I release school personnel from any liability in relation to the administration of this medication at school.
7. I have read and understand the Medication Guidelines included with this form.
8. *By typing my name on the line below I understand and acknowledge that electronically signed documents will be valid and enforced in the same manner as a hand-signed document and that a record or signature will not be denied legal effect or enforceability under law solely because it is an electronic form.*

Parent/Guardian Signature:____ Date:__________________

LICENSED SCHOOL NURSE SIGNATURE:______________________________________Date:___________

OVER

GUIDELINES FOR ADMINISTRATION OF EMERGENCY SEIZURE MEDICATION IN SCHOOL

The administration of medication to students shall be done only in exceptional circumstances wherein the student's health may be jeopardized without it.

1. Administration of Emergency Seizure Medication by school personnel will only be done according to the written order of a physician/licensed prescriber and written authorization of parent/guardian.
    a. Altered forms of medication will not be accepted or administered at school.
    b. Narcotics/medical cannabis will not be administered at school.
    c. Aspirin-containing products will not be administered at school.
    d. Only FDA approved treatments will be provided at school.

2. A new medication consent form is required when the medication dosage or instructions for administering the medication are changed.

3. New consent forms with appropriate signatures must be received each school year.

4. If the medication is discontinued, a physician/licensed prescriber is requested.

5. The medication should be brought to school by a parent/guardian in its original container. The following information must be on the medication container:
    a. Student's full name
    b. Name and dosage of medication
    c. Directions for administration must match the authorization form
    d. Physician/Licensed Prescriber name
    e. Date (must be current)

6. Medications are not to be carried by the student and will be kept in a locked cabinet or in the school health office unless authorized by the Licensed School Nurse. **Controlled substances must never be carried by a student.**

7. Special arrangements must be made with the Licensed School Nurse concerning administration of medication to students through gastrostomy tubes, rectal or injectable routes.