BONNIE CONE CLASSICAL ACADEMY

SEIZURE ACTION PLAN FOR SCHOOL

Student Name ______________________________________D.O.B.______________________ ID # ______________

School ____ Teacher_______________________________________

Physician Phone: ____

EMERGENCY CONTACTS

Name Relationship Home # Work # Cell #

1.____

2.____

3.____

Type of seizure: ____

What does the seizure look like and how long does it usually last? ____

____

Possible triggers that should be avoided: ____

____

Does student need any special activity adaptations/protective equipment (e.g., helmet) at school? ___________________

_____ No _____ Yes (explain) ____

Is student allowed to participate in physical education and other activities?

_____ No _____ Yes (explain) ____

____

ARE MEDICATIONS NEEDED TO CONTROL THE SEIZURES? _____ No _____ Yes

(List below the medications needed)

_____**Vagus Nerve Stimulator implant (see VNS management order attached)**

MEDICATIONS AMOUNT TAKEN HOW OFTEN AND FOR WHAT SIGNS

1. ____

2. ____

3. ____

Possible side effects that must be reported to parent or physician:

____

____

IF GENERALIZED SEIZURE OCCURS:

1. If falling, assist student to floor. **Note the time the seizure began.**

2. Loosen clothing at neck and waist; protect head from injury.

3. Clear away furniture and other objects from area.

4. Have another classroom adult direct student's away from area.

5. During a general or grand mal seizure expect to see pale or bluish discoloration of the skin or lips. Expect to hear noisy breathing.

6. Allow seizure to run its course; **DO NOT** restrain or insert anything into student's mouth. Do not try to stop purposeless behavior.

7. Once seizure has subsided place student in recovery position on their side, to prevent aspiration in case of vomiting.

8. **If seizure lasts more than 5 minutes activate EMS, call 911**

IF SMALLER SEIZURE OCCURS (e.g., lip smacking, behavior outburst, staring, twitching of mouth or hands)

1. Assist student to comfortable, sitting position.

2. **TIME THE SEIZURE.**

3. Stay with student, speak gently, and help student get back on task following seizure.

IF STUDENT EXHIBITS:

1. Absence of breathing or pulse.

2. Seizure of 5 minutes or greater duration.

3. Two or more consecutive (without a period of consciousness between).

4. Continued unusually pale or bluish skin or lips or noisy breathing after the seizure has stopped.

INTERVENTION:

1. **Call 911**.

2. **START CPR for absent breathing or pulse.**

WHEN SEIZURE COMPLETED:

1. Reorient and assure student.

    a. Assist change into clean clothing if necessary.
    b. Allow student to sleep, as desired, after seizure.
    c. Allow student to eat, as desired, once fully alert and oriented.

2. A student recovering from a generalized seizure may manifest abnormal behavior such as incoherent speech, extreme restlessness, and confusion. This may last from five minutes to hours.

3. Inform parent immediately of seizure via telephone conversation if:

    a. Seizure is different from usual type or frequency or has not occurred at school in past month.
    b. Seizure meets criteria for 911 emergency call.
    c. Student has not returned to "normal self" after 30-60 minutes.

4. Record seizure on Seizure Activity Log.

If you want additional care given, describe action here:

If symptoms are ____

____

Give____ (medication/dose/route)

Possible side effects ____

____

Physician Signature____ Date______________________

Print Name____ Phone______________________

I want this plan implemented for my child, _________________________________, in school. I hereby give my permission for exchange of confidential information contained in the record of my child between the nurse and physician and my signature is an informed consent to share this medical information with school staff as a need to know for academic success and emergency plan as determined by the nurse.

____

Parent Signature **Parent Printed Name** **Date**

____

Physician Signature **Physician Printed Name** **Date**

____

School Nurse Signature **School Nurse Printed Name** **Date**

BONNIE CONE CLASSICAL ACADEMY

MEDICATION PRESCRIBER/PARENT AUTHORIZATION FOR VAGUS NERVE STIMULATOR (VNS)

School Year: ________-__________

STUDENT INFORMATION
Student's Name ____ School: ___________________________________

Date of Birth: _____/_____/_____ Grade _________ Teacher ____

_____Known drug allergies/reactions If drug allergies, list: _________________Weight: ____________ lbs.

PRESCRIBER AUTHORIZATION
(To be completed by licensed healthcare provider)

START DATE: _____________________________ **STOP DATE:** ____________________________

Procedure: Swiping magnet over student's VNS

Reason for procedure: To shorten duration of, or stop, seizure activity.

How & frequency r/t swipe delivery: Swipe magnet over VNS for full 1-2 second time period, at onset of seizure activity.

Swipe may be repeated ________ time(s) if seizure activity does not cease after __________________ minute(s).

If magnet is held in place over the VNS for longer than 60 seconds at one time, the generator will be turned off until the magnet is removed. Once magnet is removed, the device will resume its normal cycle.

Do you recommend the magnet be kept "on person" by the student? □ Yes □ No
If "no", storage location of magnet will be identified in student's Individualized Healthcare Plan.

Potential Contradictions/Adverse Reactions: ____

____
Printed Name of Licensed Healthcare Provider

____ __________________ _________________ __________
Signature of Licensed Healthcare Provider **Date** **Phone** **Fax**

PARENT AUTHORIZATION
I authorize the School Nurse, the registered nurse (RN) or licensed practical nurse (LPN) to assist my child in the above procedure, and to delegate to trained, unlicensed school personnel, the task of assisting my child with the above prescribed procedure, in accordance with administrative code practice rules. I understand that additional parent/prescriber signed statements will be necessary if the procedure is changed. I also authorize the School Nurse to talk with the licensed healthcare provider should a question come up about the procedure. Procedure equipment or supplies must be registered with the school nurse or his/her designee.

____ __________________ __________________________________
Signature of Parent **Date** **Phone**

BONNIE CONE CLASSICAL ACADEMY

SEIZURE EMERGENCY CARE PLAN FOR THE BUS DRIVER

CAMPUS: ____ SCHOOL YEAR: 20_____/20_____

STUDENT NAME: ____

BUS# _________ ROUTE# ___________ GRADE: ___________ TEACHER: ______________________

PARENT/GUARDIAN NAME: ____

PHONE #: ______________________________ CELL: __________________________________

PRESENTING PROBLEM INFORMATION:

SEIZURE ACTIVITY

Rigid body, with jerking movements, not responding, may be drooling from the mouth.

EMERGENCY PLAN:

1. **STOP** the bus.
2. Stay calm, most seizures only last a few minutes.
3. Guide student to the floor.
4. Push objects away.
5. Note and record length of seizure.
6. **DO NOT** hold student down.
7. **DO NOT** put anything in person's mouth.
8. **DO NOT** give the person water, pills, or food until the person is fully alert.
9. **Call 911** if:
    - Seizure lasts more than 5 minutes
    - Student has repeated seizures without regaining consciousness
    - Student is injured or has diabetes
    - This is student's first time having a seizure.
10. After seizure, roll student onto one side to prevent choking of vomitus or saliva.
11. Check to make sure the student is breathing. Begin CPR, as needed.
12. Report incident to school and parent.

____

Parent Signature | Parent Printed Name | Date

BONNIE CONE CLASSICAL ACADEMY

Letter to Parent Regarding Administration of Medication in School

Dear Parent:

Our school has a written policy to assure the safe administration of medication to students during the school day. If your child must have medication of any type, including over the counter drugs given during school hours, you have the following choices:

1. You may come to school and give the medication to your child at the appropriate time(s).
2. You may obtain a copy of a medication form ***(Request for Medication Administration in School)*** from the school nurse or school secretary. Take the form to your child's doctor and have him/her complete the form by listing the medication(s) needed, dosage, and number of times per day the medication is to be administered. This form must be completed by the physician for both prescription and over the counter drugs, the form must be signed by the doctor and by you, the parent or guardian. Prescription medicines must be brought to school in a pharmacy-labeled bottle which contains instructions on how and when the medication is to be given. Over the counter drugs must be received in the original container, labeled with your child's name, and will be administered according to the doctor's written instructions.
   (Please see and sign page 2, Parent/Guardian responsibilities)
3. You may discuss with your doctor an alternative schedule for administering medication (i.e. outside of school hours)
4. Self-Medication: In accordance with G.S. 115C-375.2 and G. S. 115C-47, students requiring medication for asthma, anaphylactic reactions (or both), and diabetes may self-medicate with physician authorization, parent permission and a student agreement for self-carried medication. Students must demonstrate the necessary knowledge and developmental maturity to safely assume responsibility for and management of self-carry medications.

School personnel will not administer any medication to the students unless they have received a medication form properly completed and signed by both doctor and parent/guardian, and the medication has been received in an appropriately labeled container. If you have questions about the policy, or other issues related to the administration of medication at schools, please contact the school nurse at the following number: ____.

Thank you for your cooperation,

____

School Nurse Date

____

Campus Director Date

The Responsibility of the Parent or Legal Guardian

1. Limit the medications that must be given during the school day to those necessary in order to maintain the child at school.
2. Provide a written request for school personnel to administer the medication. This should be in the form of a request/permission form (Request for Medication Administration in School form). Return completed form to school. A separate parent request/permission form must be completed for each medication given at school.
3. Parents may choose to administer the medication at school themselves.
4. Complete an Authorization form, signed by a health care provider licensed to prescribe medications, which includes the following:
    a. Name of child
    b. Name of medication
    c. Date it was prescribed
    d. Dosage
    e. How the medicine is to be given at school
    f. When the medicine will be given at school
    g. Special instructions about the child receiving the medication or about the medicine itself.
    h. Until what date the medicine is to be given at school
    i. Possible side effects of the medication
    j. Possible adverse reactions to the medication
    k. Name of the health care provider and how to locate or communicate with him or her if necessary
5. Provide each medication in a separate pharmacy-labeled container that includes the child's name, name of the medication, the exact dose to be given, the number of doses in the original container, the time the medication is to be given, how it is to be administered, and the expiration date of the medication.

    Note: The parent should request of the pharmacist to provide two labeled containers – one for home use and one for school use – if child needs to be given medication both at home and at school.

6. Over the counter medications administered at school should be provided in their original packaging labeled with the student's name.
7. Provide the school with new, labeled containers when dosage or medication changes are prescribed.
8. Retrieve all unused medications from school when medications are discontinued, and /or at end of school year (according to local written policy)
9. Maintain communication with the school staff regarding any changes in the medical treatment needed at school.

____

Parent Signature Date

____

Health Office Representative Date

Bonnie Cone Classical Academy

Request for Medication Administration in School

To be completed by physician

Name of Student: ____

School: ____

Medication: (each medication is to be listed on a separate form) ____________________________________

Dosage and Route: ____

Time(s) medication is to be given: a.m.: ___________ p.m.: ___________ PRN: ______________________

Note: Medication will be given as close to prescribed time as possible but may be given up to one hour before or after prescribed time. Please advise if there is a time specific concern regarding administration.

Significant Information (include side effects, toxic reactions, reactions if omitted, etc.): ____________________

____

Contraindications to administration: ____

Physician *(printed)* **Name**: ____________________________ Address: ____________________________

Physician Contact Information: Phone: __________________________ Fax: __________________________

Physician's Signature: ______________________________________ **Date:** ____________________

**This form is invalid unless stamped and signed by the healthcare provider*

Physician's Stamp Here

I hereby give permission for my child (named above) to receive medication during school hours; administered by the health aide or director appointed staff. The medication will be furnished by me in the original container, labeled with the child's name and is to be given as stated above. I understand that medication will NOT be accepted if brought in by my child or is loose in a baggie, envelope or other container. I will count the medication with the staff and co-sign off on the medication. I give my consent to Bonnie Cone Classical Academy to contact the prescribing physician and exchange relevant medical information to clarify this medication order. I hereby release the School Board and their agents and employees from all liability that may result from my child taking this medication.

Parent/Guardian signature ____**Date:** _______________

Please document medication count ***with parent present*** below:

Date	Medication Name	Count	Expiration Date	Parent signature	Employee initials

Medication Administration Record

Student Name: ________________________________ **Medication:** ______________________________

A separate sheet is used for each medication or treatment

Key: A=Absent FT= Field Trip NS= No Show NM= No Medication in office RF= Refused ED= Early

	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MARCH	APRIL	MAY
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Additional Daily Administrations (PRN Meds only):

Date	Time	Person Administering (Name & Initials)

10700 Asbury Chapel Rd, Huntersville, NC 28078 * 704-948-4439