EL PASO COUNTY SCHOOL HEALTH SEVICES
PRACTITIONER'S WRITTEN ORDER/ SEIZURE ACTION PLAN

I. PHYSICIAN SECTION

Student's Name: _____ Date of Birth: _____ ID# _____

School Year 20 _____ -20 _____ School Name _____

Parent/Guardian: _____ Phone: _____ Cell: _____

Other Emergency Numbers: _____

Treating Physician: _____ Phone: _____ FAX: _____

Significant Medical History/Diagnosis: _____

SEIZURE INFORMATION:

Seizure Type	Average Length	Description

Last known seizure:_____Age of first seizure:_____

EMERGENCY RESPONSE:

A "Seizure emergency" for this student is defined as: _____

_____

✓ Seizure Emergency Protocol: (Check all that apply and clarify below)

☐ Call 911 for seizure lasting more than 5 minutes and/or has repeated seizures without regaining consciousness.

☐ Call 911 for difficulty breathing, student has a seizure as a result of an injury or is injured during a seizure.

☐ Administer emergency medications as indicated below

☐ Call 911 after administering emergency medication listed below

☐ Other

TREATMENT PROTOCOL DURING SCHOOL HOURS:

Daily Medication	Dose/Route/Time of day given	Common Side Effects and Special Instructions

EMEREGENCY/ RESCUE MEDICATION: ☐ This student has not been prescribed any emergency medication.

Has this student had a previous dose of ☐ **Diastat** ☐ **Intranasal Midazolam without any reported adverse reactions**? ☐ Yes ☐ No

☐ DIASTAT (DIAZAPAM RECTAL GEL): Dose: _____mg rectally for seizures lasting longer than _____minutes.
Or for seizure clusters _____ or more seizures in one hour. Minimum amount of time between doses is 4 hrs.
Maximum amount of doses in 24hr. period is_____ doses.

☐ INTRANASAL MIDAZOLAM (VERSED): To be given at onset of seizure or other:_____ ☐ 1ml vial (5mg/1ml) ☐ 2ml vial (10mg/2ml)

Total dosage to be administered: _____mg / _____ml Nasally: ½ right nostril _____ml ½ left nostril_____ml

Adverse reactions that should be reported to the physician:_____

Storage instructions:_____

Other special instructions:_____

Does student have a **Vagus Nerve Stimulator (VNS)**? ☐ Yes ☐ No

If **YES**, Describe magnet use:_____

Does this student use Oxygen: ☐ Yes ☐ No Type:_____ via:_____ at:_____liters/min

SPECIAL CONSIDERATIONS & SAFETY PRECAUTIONS: *Describe any special considerations or precautions (regarding school activities, sports, trips, etc.)*

Allowed to participate in physical activity ☐ Yes ☐ No Does the student require any protective equipment (i.e. helmet) at school ☐ Yes ☐ No

Other:_____

I understand that the emergency medication listed above may be administered by a trained unlicensed staff member and that 911 will be called whenever the above emergency medication is given. In addition for my patient I would like to add the following: _____

_____

Physician Signature: _____ **Date:** _____

II. PARENT/GUARDIAN SECTION

Parent/Guardian Authorization and Responsibility: I, the undersigned, parent/guardian of the above named student, request that all procedures and administration of medication be performed as authorized by the Health Care Provider for my child in accordance with state laws and regulations. I understand medication may only be administered by licensed health professionals, and trained unlicensed personnel, according to state laws and regulations.

I also understand that prescribed emergency medication can only be administered to my child by a school nurse or myself until medically unlicensed staff in my child's school have completed the required District training. In the absence of a medically licensed person, such as a school nurse, only designated, trained staff is authorized to perform this task and 911 will be called immediately following the administration of any emergency medication.

I agree to:
1. Notify the school nurse if any emergency medication was administered to my child within 12 hours of attending school.
2. Notify the school nurse if there are any change in my child's seizure activity and treatment plan.
4. Maintain current phone numbers with the school nurse and school office in case 911 is called.
5. Provide the necessary medication, supplies, and equipment for my child's treatment while at school.

Parent /Guardian Authorization for School Staff to Communicate Health Information
I authorize the District's designees, including District medical professionals and UAPs, to share/obtain my child's health related information with the medical health professional or health care provider identified above to plan, implement or clarify actions necessary in the administration of school related health services such as but not limited to: emergency care, care for any documented diagnosis, and medical treatments. By signing this Authorization, I readily acknowledge that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by designees authorized herein and the person(s) with whom they communicate.

_____ **Parent/Guardian initials** I authorize the school nurse to communicate with the Health Care Provider on matters related to my child's Seizure Disorder and authorized medication when necessary.

Parent/Guardian Signature: _____ Date: _____

II. SECCION DE PADRE O TUTOR

Responsabilidad de Padre/Tutor: Yo, el abajo firmante, padre o tutor del estudiante nombrado arriba, solicita que sea realizado todos los procedimientos y la administración de medicamento según lo autorizado por el proveedor de salud de mi hijo de acuerdo con las leyes y reglamentos estatales. Entiendo que el medicamento sólo puede ser administrado por profesionales de salud licenciados y personal sin licencia que ha sido entrenado conforme a las leyes y reglas estatales.

También entiendo que el medicamento prescrito de emergencia solo se puede administrar a mi hijo/a por una enfermera escolar o por mí hasta que personal de la escuela complete el entrenamiento requerido por el Distrito. En ausencia de una persona con licencia médica como una enfermera escolar, sólo el personal capacitado estará autorizado a realizar esta tarea y 911 será llamado inmediatamente después de administración de cualquier medicamento de emergencia.

Estoy de acuerdo en:
1. Notificar a la enfermera si el medicamento de emergencia fue administrado a mi hijo dentro de 12 horas de asistir a la escuela.
2. Notificar a la enfermera si hay algún cambio en la actividad convulsiva de mi hijo y/o el plan de tratamiento.
3. Mantener los números de teléfono actuales con la enfermera o la oficina escolar en caso de que se llama al 911.
4. Proporcionar el medicamento, suministros y equipos necesarios para el tratamiento de mi hijo/a en la escuela.

Autorización del padre de familia/tutor para que el Personal Escolar Comunique los Datos Médicos
Autorizo a los representantes del Distrito, incluyendo los profesionales médicos y UAPs del Distrito, a compartir con el profesional médico o proveedor de salud mencionado en la parte superior a obtener datos médicos de mi hijo/a al fin de planificar, implementar o aclarar las acciones necesarias en la administración de servicios escolares relacionados con la salud, que incluyen pero no se limitan a: atención de urgencia, cuidado para cualquier diagnóstico, o tratamientos médicos. Al firmar esta Autorización reconozco que la información usada o divulgada referente a los Datos Médicos personales e Identificables de mi hijo/a puede ser sujeto a re-divulgación por el personal autorizado y a las personas cual ellos se comuniquen.

_____ **Iniciales del Padre/Tutor**

Firma del Padre o Tutor: _____ Fecha: _____