AMSA
ADVANCED MATH & SCIENCE ACADEMY
201 Forest Street, Marlborough, MA 01752
OFFICE OF SCHOOL NURSE
Phone 508 597-2475/2473 FAX 508 485-0825

SEIZURE ACTION HEALTH CARE PLAN FOR SCHOOL 2024-25

Student Name: _____ D.O.B._____ Gr: _____

Student Picture

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)

MEDICATIONS	AMOUNT TAKEN	HOW OFTEN AND FOR WHAT SIGNS
1._____	_____	_____
2._____	_____	_____
3._____	_____	_____

List medication needed at school (name, dosage/route, and frequency) _____

_____

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

_____

IF GENERALIZED SEIZURE OCCURS:

1. If falling, assist student to floor, turn to side.
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 students away from area.
5. TIME THE SEIZURE.

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

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) seizures which total 10 minutes or greater.
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.

- Field Trip- nurse needed_____

- After school activity- no nurse, parent will be notified and accompany student _____

- Has your child ever needed their Rx Valtoco_____

Parent/Guardian Signature: _____Date _____

- Approved by School Nurse
  School Nurse Signature: _____ Date: _____

STUDENTS WITH SPECIAL HEALTH CARE NEEDS
EMERGENCY PLAN NON-MEDICAL STAFF

STUDENT NAME :_____DOB:_____TEACHER:_____RM/GRADE :_____

PARENT/GUARDIAN:_____PREFERRED HOSPITAL:_____

HOME PHONE #:_____WORK #:_____ CELL #:_____

EMERGENCY CONTACT:_____ PHONE:_____OTHER PHONE:_____

PHYSICIAN:_____ PHYSICIAN TEL:_____ PHYSICIAN FAX:_____

STUDENT-SPECIFIC EMERGENCIES

IF YOU SEE THIS	***DO THIS***

IF AN EMERGENCY OCCURS:

1. If the emergency is life-threatening, immediately call 911.
2. Stay with student or designate another adult to do so.
3. Call or designate someone to call the principal and/or school nurse.
   a. State who you are.
   b. State where you are.
   c. State problem.

DOCUMENTATION OF STAFF TRAINING

DATE:	**TRAINED BY:**	**STAFF NAME:**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

STUDENTS TRANSPORTED WITH SPECIAL EQUIPMENT/NEEDS

BUS DRIVER/ATTENDANT INFORMATION SHEET

STUDENT NAME : _____ SCHOOL:_____
ADDRESS:_____ TEACHER: _____

PARENT/GUARDIAN:_____ AM ROUTE:____PM ROUTE:____

HOME PHONE #:_____ WORK #:_____ CELL #:_____

EMERGENCY CONTACT:_____ PHONE:_____ OTHER PHONE:_____

PHYSICIAN:_____ PHYSICIAN TEL:_____ PHYSICIAN FAX:_____

SPECIAL EQUIPMENT OR MEDICAL NEEDS ON BUS

I.E. OXYGEN TANK, WHEELCHAIR, SEIZURES, GO-BAGS, ETC.- PLEASE INCLUDE SIZE AND DIMENSIONS OF ALL EQUIPMENT

EMERGENCY BUS PLAN

IF YOU SEE THIS	*DO THIS*

BEHAVIOR PLAN

BEHAVIOR OR DISABILITY: _____

INTERVENTION TO MANAGE THE BEHAVIOR/DISABILITY

_____

_____

OTHER SPECIFIC NEEDS FOR SAFELY TRANSPORTING STUDENT

_____

_____

DOCUMENTATION OF DRIVER/ATTENDANT TRAINING

DATE	DRIVER/ATTENDANT NAME	NURSE/SCHOOL OFFICIAL

AMSA
ADVANCED MATH & SCIENCE ACADEMY

201 Forest Street, Marlborough, MA 01752
OFFICE OF SCHOOL NURSE
Phone 508 597-2475/2473 Medical FAX 508 597-0825

PARENT/GUARDIAN CONSENT FOR MEDICATION ADMINISTRATION 2024-25

Name of Student _____ Date of Birth: _____Grade 6 7 8 9 10 11 12

My child is currently receiving the following medications:(please list all medications the child is receiving, including those given during the school day.)

1. _____ 2._____ 3._____4. _____

My son/daughter has the following food or drug allergies: _____

**********Consent**********

1. I consent to have the school nurse or his/her delegate administer the medication:
   _____(
   Name of medication)
2. I give permission for my child to self-administer medication, if the school nurse determines it is safe and appropriate (check one) _____ yes _____ no
3. I give permission to the school nurse to share information relevant to the prescribed medication administration as he/she determines appropriate for my child's health and safety.
4. I agree to provide unexpired medications in the original, properly dated and labeled container. I will keep a dosage count and record of expiration date at home and will deliver refills as needed. I will promptly pick up any unused medications. I understand I may retrieve the medication from the school at any time; however, the medication will be destroyed if it is not picked up within one week following termination of the order or on the last day of this school year.
5. How do you want to handle medication administration during times when your child is attending a field trip? Please be aware that a school nurse are not always available for field trips.
   - My child needs this medication on field trips ☐ Yes ☐ No
   - When there is not a nurse on the field trip, do you want to be notified? ☐ Yes ☐ No
   - When there is not a nurse on the field trip, a parent will attend the Field Trip to administer the medication
     ☐ Yes ☐ No
6. Please be aware that there is not availability for medication administration during afterschool events (sports/clubs, etc.)

_____ _____ _____

Parent/Guardian Signature **Relationship to student** **Date**

FOR HEALTH OFFICE USE ONLY

Possible Side effects and Required Storage Conditions: See attached forms. Name of Medication: _____

Date. received _____ amount _____delivered by _____ expires on: ____/____/____

Location where medication administration will occur: ☐ Health Office ☐ Other (specify): _____

Notes/Information:

Disposition of Medication: ☐ Finished ☐ Returned to parent/guardian ☐ Given to Student ☐ Disposed- Witness_____

Date_____ Date: _____ Date: _____ Date: _____

AMSA
201 Forest Street, Marlborough, MA 01752
OFFICE OF SCHOOL NURSE Phone 508 597-2475/2473 – Medical FAX 508 485-0825

Contract for Permission to Carry and Self Administer Seizure Medications

Name of Student: _____ Grade: 6 7 8 9 10 11 12

To be completed by the Parent/Guardian:

Qualified students will be allowed to carry their Seizure medications with them in school and on field trips at the discretion of the school nurse. Parents only need to sign the agreement. The school nurse and your child complete the rest of the form. Please contact the school Nurse if there are any changes to your child's medication and/or treatment plan during the school year.

I request that my child be permitted to carry on his/her person the medication that has been prescribed. My child has been instructed in and understands the purpose, appropriate method, frequency, and use of his/her medication. My child understands that he/she is responsible and accountable for carrying and using his/her medication. My child understands that he/she will be responsible for carrying and self-administering this medication under the contract agreement level checked below. It is understood that if there is irresponsible behavior or safety risk, the privilege of carrying his/her medication will be rescinded. I will support my child in following the agreement

Parent/Guardian Signature: _____ Date: _____

CONTRACT AGREEMENT: Check One

- ☐ **COP (Carries on person at all times)**
- ☐ **FTAS (Field Trips/Sports/ After School Activities)**
- ☐ **DNC (Does Not Carry. Chaperone/coach/club leader carries and student to be with them for duration of event)**
- ☐ **Other to be determined by Sch. Nurse:** _____

To be completed by School Nurse and Student		
Physicians order for this medication is on file in the Health Office	Yes ☐	No ☐
Student is consistently able to name and identify the correct medication, knows the correct dosage, time it needs to be administrated and purpose of the medication	Yes ☐	No ☐
Student can explain the proper storage requirements of his/her medication and agrees to follow those medication storage requirements	Yes ☐	No ☐
Student demonstrates safe and correct use/administration of medication and agrees to carry only the amount of medications required.	Yes ☐	No ☐
Student agrees to be responsible to provide and carry his/her own medication on field trips/after school activities/sports. If student forgets to bring his/her medication, & there is no backup in H.O. then 911 will be called if medication is required	Yes ☐	No ☐
Student agrees that after administering this medication he/she will immediately inform a faculty member to call 911.	Yes ☐	No ☐
Student realizes his/her responsibility in carrying his/her own medication(s) and agrees ***NEVER*** share the medication(s) with others.	Yes ☐	No ☐
Student agrees to maintain a backup medication in the health Office	Yes ☐	No ☐
The student understands that the privilege of carrying and administering his/her own medication(s) will be rescinded if he/she does not follow the above agreement.	Yes ☐	No ☐
Expiration date on Medication in HO is _____ Expiration date on Medication student is carrying is _____		
Amount of medication student can carry _____		
I give permission to notify staff of my plan of self-administration. I understand that if I do not follow the plan of self-administration according to guidelines stated above, or misuse my medication in any way, this agreement will be immediately terminated. Written notification of termination will be sent by nurse to my parents and teachers within 24 hours.		
Student Signature: Date:		
This student ☐ does ☐ does not demonstrate the required responsibilities This student ☐ may ☐ cannot carry/self-administer the medication.		
Nurse Signature: Date:		