

Dear Parents/Guardians

If a Seizure Rescue Medication (Valtoco/ Diastat) is required for administration for the next school year (August 2025- June 2026) please remember to follow these important steps:

Medical Orders must be written and dated after July 1st, 2025. Medical orders are only active for the current school year.

- Medical providers must provide **medication orders** that include the name of the medication, form of medication (nasal, rectal), frequency, times of administration, diagnosis for which medication is being ordered and any side effects or specific directions/information for administration.
- Medical providers must provide a **(1)Seizure Action Plan & (2) Please review and sign with a medical provider the Emergency Action Plan for Non Nursing Staff -this will be used for campus non-medical staff when a nurse is not on campus/after school activities/field trips and bus drivers.**
- Please bring medications to school before the first day of classes. They must be in the original pharmacy packaging with your student's name on it and non-expired. **You may call the Health Office after August 20, 2025, to arrange a drop-off.** No student is allowed to carry any medications to school, even over-the-counter medication.
- Please review the AMSACS medication administration policy. If a student is COP then a second dose of medication will be stored in the Health Office.
- **No student will be allowed to attend a field trip until their Seizure/Epilepsy paperwork is completed, and the student has brought their seizure rescue medication to the Health Office prior to the event.**

PARENT/GUARDIAN SEIZURE RESCUE MEDICATION CHECK LISTS

Checklist for Required Paperwork for Seizure Rescue medication

Documents from the medical provider needed:

1. _____ Medical Order Form
2. _____ Seizure Rescue Action Plan/ Health Care Plan for School
3. _____ Sign the Seizure Emergency Action Care Plan for Non-Medical Staff/Bus Driver/After School Activities

Parent to Complete:

1. _____ Parent's Permission for Seizure Rescue Medication Administration Plan (MAP)
2. _____ Contract to carry if applicable
3. _____ Sign the Seizure Emergency Action Care Plan for Non-Medical Staff/Bus Driver/After School Activities

Please be aware that if you feel your child has needs beyond the medical provider's seizure action plans you may call Guidance for a 504 Plan.

If you need this information translated, please copy and paste it into Google Translate. The link to Google Translate is <http://translate.google.com/>

2025-26 Advanced Math and Science Academy Charter School

Parent/Guardian Permission/ Medication Administration Plan (MAP) for Seizure Rescue Medication

Form with fields for Student Name, DOB, Grade, Name of Licensed Prescriber, Phone Number, Emergency Contact, and Parent/Guardian Name, Home Phone, Cell Phone.

Name of Medication: _____ Date of Medical Order (received after July, 1 2025): _____

Diagnosis: (Type of seizure and what it looks like for your child)

Allergies to Food or Medication: (Specify Allergy)

Other medication being taken by my student (if not in violation of confidentiality):

() I give permission for my child to self-carry their rescue seizure medication if the school nurse determines it is safe and appropriate.

**** If the student will be self-carry, please fill out second page "Contract for Permission to Carry"

How do you want to handle medication administration during times when your child is attending a school function/event, after school hours (clubs/sports, etc.), during off school activities during day/overnight field trips? (Please check one only)

- a. COP (Carries on Person at all times)
b. FTAS (Carries only on field trips and after school activities)
c. DNC (Does not carry- Nurse to carry and be with student during entire event)
d. Parent to attend field trip/activity

() I understand that a parent/guardian must drop off medication to the school nurse and it must be in it the original pharmacy packaging with student's name and the appropriate label.

() I give permission to the school nurse to administer the above rescue seizure medication to my child per medical orders/seizure action plan. Once administered 911 will be called and a parent notified

() I give permission to the school nurse to share with appropriate school personnel/bus driver the information related to the prescribed medication as deemed necessary for my child's health and safety.

Does your student take the bus () Bus #/Name () Is your child a parent pick/up/drop off

() I understand that for this medication to be discontinued I need an updated medical note from the student's provider.

***Please be aware that there is no availability for medication administration during after school activities other than staff are trained for EpiPen administration only. 911 will be called. Please call the Health Office to discuss any after-school activities.

Parent/Guardian Signature: Relationship to Student: Date:

FOR HEALTH OFFICE USE ONLY: School Nurse Signature: Date:

Name of the Med. Ordered:

Date of Medical Order (received after July 1,2025): Required Storage: ()Locked; labeled in the Health Office () COP

Duration of Med. (Start Date; End Date): / / ; / / Quantity of Med. Received and Date Expiration Date on medication: HO COP

Dosage: Frequency: Specific Time: see Medical orders/Seizure Action Plan Route of Administration:

Disposal of medication: () Finished ()Returned to parent/Guardian ()Given to Student Nurse's Signature: Date:

() Disposed/Witness: Date:

***** Attach Medical orders & Medical Care Plan for School***** Edited 6/12/25 MGW

Attach Student Photo:

2025-26 Contract for Permission to Carry Seizure Rescue Medication (Diazepam)

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 rescue medication 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 seizure rescue 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 his/her medication. My child understands that he/she will be responsible for carrying the 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) Nurse carries and student to be with them for duration of event
- Other to be determined by School Nurse: _____

To be completed by School Nurse and Student

Medical order for seizure rescue medication is on file in the Health Office.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Student is consistently able to name and identify the correct medication, knows the correct dosage, and can explain the purpose of the medication.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Student can explain the proper storage requirements of his/her medication and agree to follow those medication storage requirements: The rescue med will be carried on person and a second locked in the Health Office labeled "Seizure medication- Valtoco/ Diastat".	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Student demonstrates safe and correct use/administration of rescue medication.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Student agrees to maintain a backup seizure rescue medication in the Health Office	Yes <input type="checkbox"/>	No <input type="checkbox"/>
The presence of a nurse on a field trip, sports, after school event is not guaranteed. Student agrees to be responsible to provide and carry his/her own seizure rescue medication on field trips/after school activities/sports.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Student agrees, per medical orders/care plan if a nurse needs to administer a rescue medication 911 will be called.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Student realizes his/her responsibility in carrying his/her own medication(s) and agrees to NEVER share the medication(s) with others.	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Expiration date on Medication in Health office is _____ Expiration date on Medication student is carrying is _____

Amount of medication student can carry One box of seizure rescue meds

I give permission to notify staff of my plan of Carry-on-Person. I understand that if I do not follow the plan of Carry-On-Person/ Nurse 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:** _____

SEIZURE EMERGENCY ACTION CARE PLAN FOR SCHOOL 2025-26 NON-MEDICAL STAFF/BUS DRIVER/AFTER SCHOOL ACTIVITIES

Student Name: _____ DOB: _____ Grade: _____ Name of Licensed Prescriber: _____ Phone Number: _____ Emergency Contact; Name/Number: _____	1. Parent/Guardian Name: _____ Home Phone: _____ Cell Phone: _____ 2. Parent/Guardian Name: _____ Cell Phone: _____
------------------------------------------------------------------------------------------------------------------------------------------------------	---------------------------------------------------------------------------------------------------------------------------------

Type of Seizure: _____ What does the seizure look like and how long does it usually last?

Possible triggers that should be avoided: _____

Is the student allowed to participate in physical education and other activities? _____ No _____ Yes (explain any limitations)

ARE MEDICATIONS NEEDED TO CONTROL THE SEIZURES? _____ No _____ Yes (List below the medications needed- daily meds at home) **MEDICATIONS(Dose & How often):** _____

IF GENERALIZED SEIZURE OCCURS (SEIZURE FIRST AID) - Call for a nurse; If No nurse is available call 911 & parent

- If falling, assist student to the floor, turn to the side.
- Loosen clothing at neck and waist; protect head from injury.
- Clear away furniture and other objects from the area.
- Have another classroom adult direct students away from area.
- **TIME THE SEIZURE.**
- Allow seizure to run its course; DO NOT restrain or insert anything into student's mouth. Do not try to stop purposeless behavior.
- During a general or grand mal seizure expect to see pale or bluish discoloration of the skin or lips. Expect to hear noisy breathing.
- **WHEN SEIZURE COMPLETED: Call Parent(s)** Reorient and assure student. Allow student to sleep, as desired, after seizure.
- 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.

IF SMALLER SEIZURE OCCURS(e.g., lip smacking, behavior outburst, staring, twitching of mouth or hands) **Call for a nurse; If no nurse is available call parent**

- Assist student in a comfortable, sitting position.
- Time the seizure.
- Stay with student, speak gently, and help student get back on tasks following seizure.

WHEN TO CALL 911:

- Absence of breathing or pulse. Start CPR & call 911
- **Seizure of 5 minutes or greater duration. The nurse has students rescue medication in the HO & 911 will be called**

***** **No staff can administer the rescue medication** *****

- Two or more consecutive (without a period of consciousness between) seizures which total 10 minutes or greater- call 911
- Continued unusually pale or bluish skin or lips or noisy breathing after the seizure has stopped.
- Student is injured or has Diabetes
- Student has first time seizure

If you want additional care given, describe action here:

If symptoms are

Physician Signature _____ **Print Name:** _____ **Phone:** _____ **Date:** _____

- 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 School Nurse and Medical Provider, 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/Diastat _____

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

Add student Photo: