SCS
SCOTT COUNTY SCHOOLS

Dear Parent/Guardian:

According to our health records, your child has a history of seizures that may require having emergency medications on hand for possible seizures.

Enclosed are the forms that need to be completed by the Parent/Guardian and/or Physician and returned to the School Nurse. We **must** have the medication form along with the medication so that staff may administer it in case of an emergency.

The information on these forms will help us determine how best to help your child during the school day and will be distributed to appropriate school personnel on a need-to-know basis and may include bus drivers, substitute teachers, cafeteria staff, and others who work with your child daily.

To help your child, please let us know of any changes in your child's medical condition or emergency daytime phone numbers.

The following forms need to be completed and returned to your child's school at the start of the school year.

- Administration of Medication Form (parent and physician)
- Seizure HealthCare Plan (physician)
- Seizure Parent Questionnaire (parent)

Please contact the School Nurse if you have any questions.

We are looking forward to a great year with your student!

Scott County School District Nurse

Billy Parker, Superintendent
2168 Frankfort Road | Georgetown, Kentucky 40324 | 502-863-3663 | www.scott.kyschools.us
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Management of Students with Seizures Guidelines

SCOTT COUNTY SCHOOLS are committed to fully meeting the needs of pupils who have epilepsy, keeping them safe, ensuring they achieve to their full potential, and are fully included in school life. This may include:

- Keeping careful records of changes in behavior and levels of achievement to identify pupils who are not achieving to their full potential.
- Tackling any problems early.
- Ensuring that all pupils with epilepsy are fully included in school life, activities and outings (day and residential) and are not isolated or stigmatized.
- Giving voice to the views of pupils with epilepsy, for example regarding feeling safe, respect from other pupils, teasing and bullying, what should happen during and following a seizure, adjustments to support them in learning, adjustments to enable full participation in school life and raising epilepsy awareness in school.
- Making necessary adjustments e.g. exam timings, coursework deadlines, timetables
- Liaising fully with parents and health professionals (with the parent's permission) to share information about the pupil's education, healthcare, medication and any affects this has on their school life (for example epilepsy medication and seizures can affect a person's ability to concentrate). This will be an ongoing process.
- Ensuring that staff are epilepsy aware and know what to do if a pupil has a seizure.
- Ensuring that there will be a trained member of staff available at all times to deliver emergency medication.
- Every student with epilepsy will have an Individual Health Care Plan in place, which will include information on the pupil's seizures, medication, and emergency protocols.
- Raising awareness of epilepsy across the whole school community, including pupils, staff and parents.

PARENTS/GUARDIANS are expected to be an active liaison for their child by:

- Notifying the school of seizures related to a disabling condition or medical necessity.
- Filling out and returning the Medication Administration Form, Seizure Action Plan, and Parent Questionnaire.
- Providing medical information from a District-approved recognized medical authority (RMA) authorized to practice within the State of Kentucky as noted in the student's IEP, 504 plan, or health plan.
- Providing updated medical information as requested by the District.
- Participating in any meetings or discussions regarding the child's health plan.
- Notifying the school of any changes relating to his Epilepsy.

7/9/23

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EPILEPSY FOUNDATION

Seizure Action Plan

Effective Date

This student is being treated for a seizure disorder. The information below should assist you if a seizure occurs during school hours.

Student's Name | Date of Birth

Parent/Guardian | Phone | Cell

Other Emergency Contact | Phone | Cell

Treating Physician | Phone

Significant Medical History

Seizure Information

Seizure Type	Length	Frequency	Description

Seizure triggers or warning signs:

Student's response after a seizure:

Basic First Aid: Care & Comfort

Please describe basic first aid procedures:

Does student need to leave the classroom after a seizure? ☐ Yes ☐ No

If YES, describe process for returning student to classroom:

Basic Seizure First Aid

- Stay calm & track time
- Keep child safe
- Do not restrain
- Do not put anything in mouth
- Stay with child until fully conscious
- Record seizure in log

For tonic-clonic seizure:

- Protect head
- Keep airway open/watch breathing
- Turn child on side

Emergency Response

A "seizure emergency" for this student is defined as:

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

- ☐ Contact school nurse at _____
- ☐ Call 911 for transport to _____
- ☐ Notify parent or emergency contact
- ☐ Administer emergency medications as indicated below
- ☐ Notify doctor
- ☐ Other _____

A seizure is generally considered an emergency when:

- Convulsive (tonic-clonic) seizure lasts longer than 5 minutes
- Student has repeated seizures without regaining consciousness
- Student is injured or has diabetes
- Student has a first-time seizure
- Student has breathing difficulties
- Student has a seizure in water

Treatment Protocol During School Hours (include daily and emergency medications)

Emerg. Med. ✓	Medication	Dosage & Time of Day Given	Common Side Effects & Special Instructions

Does student have a **Vagus Nerve Stimulator?** ☐ Yes ☐ No If YES, describe magnet use:

Special Considerations and Precautions (regarding school activities, sports, trips, etc.)

Describe any special considerations or precautions:

Physician Signature _____ **Date** _____

Parent/Guardian Signature _____ **Date** _____

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Questionnaire for Parent of a Student with Seizures

Please complete all questions. This information is essential for the school nurse and school staff in determining your child's special needs and providing a positive and supportive learning environment. If you have any questions about how to complete this form, please contact your child's school nurse.

Contact Information

Student's Name | School Year | Date of Birth

School | Grade | Classroom

Parent/Guardian | Phone | Work | Cell

Parent/Guardian Email

Other Emergency Contact | Phone | Work | Cell

Child's Neurologist | Phone | Location

Child's Primary Care Doctor | Phone | Location

Significant Medical History or Conditions

Seizure Information

1. When was your child diagnosed with seizures or epilepsy? _____
2. Seizure type(s)

Seizure Type	Length	Frequency	Description

3. What might trigger a seizure in your child? _____
4. Are there any warnings and/or behavior changes before the seizure occurs? ❒ YES ❒ NO
   If YES, please explain: _____
5. When was your child's last seizure? _____
6. Has there been any recent change in your child's seizure patterns? ❒ YES ❒ NO
   If YES, please explain: _____
7. How does your child react after a seizure is over? _____
8. How do other illnesses affect your child's seizure control? _____

Basic First Aid: Care & Comfort

9. What basic first aid procedures should be taken when your child has a seizure in school?

10. Will your child need to leave the classroom after a seizure? ❒ YES ❒ NO
    If YES, what process would you recommend for returning your child to classroom:

Basic Seizure First Aid

- Stay calm & track time
- Keep child safe
- Do not restrain
- Do not put anything in mouth
- Stay with child until fully conscious
- Record seizure in log

For tonic-clonic seizure:

- Protect head
- Keep airway open/watch breathing
- Turn child on side

Seizure Emergencies

11. Please describe what constitutes an emergency for your child? (Answer may require consultation with treating physician and school nurse.)

12. Has child ever been hospitalized for continuous seizures? ❒ YES ❒ NO
    If YES, please explain:

A seizure is generally considered an emergency when:

- Convulsive (tonic-clonic) seizure lasts longer than 5 minutes
- Student has repeated seizures without regaining consciousness
- Student is injured or has diabetes
- Student has a first-time seizure
- Student has breathing difficulties
- Student has a seizure in water

Seizure Medication and Treatment Information

13. What medication(s) does your child take?

Medication	Date Started	Dosage	Frequency and Time of Day Taken	Possible Side Effects

14. What emergency/rescue medications are prescribed for your child?

Medication	Dosage	Administration Instructions (timing* & method**)	What to Do After Administration

** After 2nd or 3rd seizure, for cluster of seizure, etc.* *** Orally, under tongue, rectally, etc.*

15. What medication(s) will your child need to take during school hours? _____
16. Should any of these medications be administered in a special way? ❒ YES ❒ NO
    If YES, please explain: _____
17. Should any particular reaction be watched for? ❒ YES ❒ NO
    If YES, please explain: _____
18. What should be done when your child misses a dose? _____
19. Should the school have backup medication available to give your child for missed dose? ❒ YES ❒ NO
20. Do you wish to be called before backup medication is given for a missed dose? ❒ YES ❒ NO
21. Does your child have a Vagus Nerve Stimulator? ❒ YES ❒ NO
    If YES, please describe instructions for appropriate magnet use:

Special Considerations & Precautions

22. Check all that apply and describe any consideration or precautions that should be taken:

❒ General health _____ ❒ Physical education (gym/sports) _____
❒ Physical functioning _____ ❒ Recess _____
❒ Learning _____ ❒ Field trips _____
❒ Behavior _____ ❒ Bus transportation _____
❒ Mood/coping _____ ❒ Other _____

General Communication Issues

23. What is the best way for us to communicate with you about your child's seizure(s)? _____

24. Can this information be shared with classroom teacher(s) and other appropriate school personnel? ❒ YES ❒ NO

Dates _____
Updated _____

Parent/Guardian Signature _____ **Date** _____

Permission Form for Prescribed or Over-the-Counter Medication

School: _____ Date form received by the School: _____

Student's Name: _____ **Grade:** _____ **Homeroom/Classroom:** _____

Student's Age: _____ **Date of Birth:** _____

TO BE COMPLETED BY THE PHYSICIAN OR HEALTH CARE PROVIDER FOR PRESCRIPTION AND NON-PRESCRIPTION (OVER-THE-COUNTER "OTC") MEDICATION

Name of medication: _____ Reason for medication: _____

Form of medication/treatment: ☐ Tablet/capsule ☐ Liquid ☐ Inhaler ☐ Injection ☐ Nebulizer ☐ Other _____

Describe schedule and dose to be given at school: _____

Starting Date: ☐ date form received ☐ Other, as specified: _____

Stopping Date: ☐ for episodic/emergency events only ☐ end of school year ☐ Other date/duration: _____

Special storage requirements: ☐ None ☐ Refrigerate ☐ Other _____

Restrictions and/or important side effects: ☐ No restrictions/side effects ☐ Yes. Please describe:

_____

NOTE: ***In the event the Principal/designee is notified of the possibility of an adverse or extreme reaction to a medication, s/he shall inform the student's teacher(s) of such a possibility before the student begins the medication schedule.***

Pursuant to KRS 158.832 to 158.836, Scott County Schools permits a student to possess and self-administer medications for asthma, diabetes, or anaphylaxis at school and at school-related function upon completion of the following information by the parent/guardian and the student's physician and waiver of liability by the parent/guardian.

Student has been instructed in self-administering the medication to be completed for asthmatic, diabetic, or severe allergic reactions (anaphylaxis) ONLY: ☐No ☐Supervision Required ☐ Supervision Not Required

Student must carry this medication on his/her person: ☐No ☐Yes

Please indicate additional information: ☐ On the back side of this form ☐ As an attachment

_____ _____

Physician/Health Care Provider Signature ***Date***

_____ _____

Signature of Parent/Guardian ***Date***

Name of Physician/Health Care Provider: _____

Address: _____

Phone #: _____ **Fax #:** _____

To the school: Please report concerns about medications or the student's condition to the above physician/health care provider.

SCHOOL PERSONNEL: PLEASE ENSURE PAGE 2 OF THIS FORM IS ALSO COMPLETED.