

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 _____

PATERSON PUBLIC SCHOOL

ACTIVITY LIMITATION FORM

PS#: _____ (973) 321- _____ DATE GIVEN: _____ DATE RETURNED: _____

STUDENT: _____ DOB: _____ GRADE/HR: _____

Dear Doctor:

Our records indicate that the above named student requires an individual activity plan. Please provide a diagnosis and what accommodations, if any, are needed. Will you kindly check below the activities that the student may participate in.

PROGRAM OF FULL PARTICIPATION: _____ YES _____ NO

Relating to *DIAGNOSIS*: _____

Student **MAY PARTICIPATE FULLY** in the school program **WITHOUT RESTRICTIONS**.

PHYSICIAN PRINT/STAMP: _____ PHONE: _____

PHYSICIAN SIGNATURE: _____

OR:

PROGRAM OF RESTRICTED ACTIVITY: Start date: _____ End Date: _____

Relating to *DIAGNOSIS*: _____, the following plan is indicated.

<i>Student MAY PARTICIPATE</i> in the following activities:	YES	NO
WARM-UP EXERCISES: Stretching , walking		
LOW IMPACT AEROBICS: Jumping, hopping, jogging, dance, Zumba		
SWIMMING:		
STUNTS: Tumbling, rolling, balance, strength		
PHYSICAL FITNESS TESTING: Running, sit-ups, push-ups, pull-ups		
NON-CONTACT GAMES: Paddle ball, jump rope, badminton, tennis, bowling, other racket sports		
WEIGHT TRAINING PROGRAM: Free weights, treadmill		
TRACK AND FIELD: Sprints, intermediate & distance running, long jump, high jump, shot-put		
APPARATUS: Climbing, vaulting, support, suspension		
COMPETATIVE GAMES: Soccer, hockey, basketball, baseball, softball, volleyball, speedball, touch football		
RECESS PLAY:		

STAIR CLIMBING (Circle) : YES NO * Number of flights of stairs allowed per day _____

USE OF HELMET in gym: YES NO in recess: YES NO in class: YES NO

OTHER PROTECTIVE and/or ASSISTIVE DEVICES (please specify): _____

OTHER RESTRICTIONS: _____

PHYSICIAN PRINT /STAMP _____ PHONE: _____

PHYSICIAN SIGNATURE _____ DATE: _____

_____ INITIAL EXAM _____ ANNUAL FOLLOW UP

SCHOOL #

SCHOOL YEAR

PATERSON PUBLIC SCHOOLS

**AUTHORIZATION FOR THE ADMINISTRATION OF PRESCRIPTION AND NON-PRESCRIPTION MEDICATIONS
TO BE GIVEN DURING REGULAR SCHOOL HOURS**

Date Given _____ Date Returned _____ Medication Started (1st dose) _____

Student's Name _____ DOB ____ / ____ / ____ Grade _____

PHYSICIAN: (medications to be given during regular school hours)

Please give the above named student the following;

Medication: _____

Dosage: _____

Time: _____

Purpose: _____

Diagnosis: _____

Medication to be taken during regular school hours:

Printed Name of Physician: _____ Address: _____

Physician's Signature: _____ Telephone: _____
Fax #: _____

PARENT:

I hereby give my permission for the above prescription to be given to: _____
(Print Student Name)

Parent/Guardian Signature _____ Date _____

APPROVED:

I hereby approve the above request for medication to be given during regular school hours.

School Doctor / Administrator _____ Date _____

All medications must be brought to the school by a responsible adult in the original container, appropriately labeled by the pharmacy.
All medications must be counted by the school nurse, in the presence of the parent/guardian, and signed for.

All medications will be kept in a locked cabinet in the School Health Office, and administered by the School Nurse at the appropriate time.

School Nurse _____ 973-321- _____



PATERSON PUBLIC SCHOOLS

Charles Riley School # 9

6 Timothy Street

Paterson, NJ 07503

(973) 321-0090/ Fax: (973) 321-0255



Domenico Carriero, Principal
Alexis Bermudez, Vice-Principal
Elenh Andreanidis, Vice-Principal

Eileen Shafer
District Superintendent

Health Office
Office (973) 321-0099 Fax: (973) 321-0255
Namaty Asfour RN, BSN

Parent/Guardian Permission to Release and Exchange Confidential Health Information

Student Name: _____

DOB: _____

Address: _____

Student ID# _____

To Whom It May Concern:

This is to certify that I, _____, the parent/legal guardian of _____,
(Parent/Guardian Name) (Student Name)

hereby authorize an exchange of information regarding my child, _____, to occur between the
(Student Name)

School Nurse and staff members who interact with _____
(Student Name)

This information may also be shared with the Intervention and Referral Service Team, Child Study Team,
and/or with the 504 team if needed.

This authorization is in effect for the School Year: _____

Parent/Guardian Name (Print): _____

Parent/Guardian Signature: _____

School Nurse: _____

Date: _____

Telephone: 973-321-0099