



OCEAN VIEW SCHOOL DISTRICT
Educational Support Services/Health Services
714-847-2551 ext. 1314 ♦ 714-596-7078 FAX



Questionnaire for Parents of Child with a Seizure Disorder

Please print:

School Year: _____ Date: _____
 Student Name: _____ Birth Date: _____ Grade: _____
 Parent Name: _____ Home #: _____ Work #: _____
 Physician Name: _____ Telephone: _____

You have notified the school that your child has a seizure disorder. The following information will be helpful to your child's school nurse and school staff in determining any special needs for your child. Please answer to the best of your ability and return this form to the school office. Thank you!

Nurse's Name: _____ Telephone: _____

Seizure History

- Seizure Description:
 - Seizure type: _____
 - Date of last seizure: _____
 - Predictable frequency? Yes No
 - Usual frequency (fill in appropriate number) _____ per day _____ per week
 _____ per month _____ per year
 - My child's seizures last _____ seconds _____ minutes
 - My child's seizures occur: _____ anytime _____ morning _____ afternoon
 _____ evening _____ night _____ while asleep _____ other
 - The following seems to trigger seizures: _____ illness _____ light
 _____ missed medications _____ lack of sleep _____ change in diet
 _____ restricted activity _____ emotional stress _____ other
 - My child has an aura (warning) beforehand: _____ always _____ usually
 _____ sometimes _____ does not
- My child's aura before a seizure is: _____
- My child's seizures look like: _____
 - After a seizure, my child: _____
 May child takes _____ minutes to resume activities.
 - Please list the medications your child receives:

_____	Daily <input type="checkbox"/>	As needed <input type="checkbox"/>
_____	Daily <input type="checkbox"/>	As needed <input type="checkbox"/>
_____	Daily <input type="checkbox"/>	As needed <input type="checkbox"/>



OCEAN VIEW SCHOOL DISTRICT
Student Services/Health Services
Seizure Action Plan



Student Name _____ DOB _____ Date _____

Severe Seizures

Stiffening or rigidity, followed by muscle jerks; may vomit; may have shallow, rapid, or temporary suspended breathing; student may be pale or skin and lips turn blue. Normal breathing then resumes, fatigue will be apparent. After the seizure, a period of deep sleep occurs lasting from minutes to hours. *May last 2 to 5 minutes.*

Emergency Response

A "seizure emergency" for this child is defined as: _____

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

- Contact School Nurse
- Call 911 for transport to _____
- Notify parent or emergency contact
- Parent to notify doctor
 CHOC Neurology Clinic at 714-532-7601(M-F 8-4:30) or 866-316-3347 (after hours)
- Administer emergency medications as indicated below
- Other _____

"As Needed" Treatment Protocol

1. Does child have a **Vagus Nerve Stimulator (VNS)**?
 Yes No
 If yes, describe magnet use: _____
2. **Emergency Medication:** Diastat / Valtoco _____ mg
 - Immediately call School Nurse and 911
 - Trained personnel will administer medication when indicated

Special Considerations & Safety Precautions: (re: school activities, sports, trips, etc.)

- None
 - No contact sports
 - No use of power tools/power equipment
 - No swimming
 - Other: _____
- Does child need to leave the classroom after a seizure? Yes No
 If yes, describe the process for returning child to classroom: _____

Authorized Health Care Provider Signature _____ Authorized Health Care Provider (printed) _____ Telephone _____ Date _____	<i>Office Stamp</i>
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<p align="center">Parent Consent for Management of Seizures at School</p> <p>I (We), the parent/guardian of the above named student request that the following for Management of Seizures in school be administered to our child in accordance with state laws and regulations. I will:</p> <ol style="list-style-type: none"> 1. Provide the necessary supplies and equipment, including 3 day emergency supply of medication. 2. Notify the school nurse if there is a change in the student health status or change of physician. 3. Notify the school nurse immediately and provide new consent for any changes in doctor's orders. <p>I authorize the school nurse to communicate with the Authorized Health Care Provider when necessary. I understand that I will be provided a copy of my child's completed Individual School Healthcare Plan (ISHP).</p> Parent Signature: _____ Date: _____ School Nurse Signature: _____ Date: _____
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PARENT/GUARDIAN AND AUTHORIZED HEALTH CARE PROVIDER REQUEST FOR TREATMENT

Name of Student: Birth date: Grade/Track: School/District: Teachers Name:

California Education Code Section, 49423.5 allows the school nurse to train monitor and supervise non-medical school personnel to assist students who require treatment during the school day.

I request that the following treatment(s) be administered to my child as ordered by the authorized health care provider: Routine Seizure Care

I understand that designated non-medical school personnel will administer treatment under supervision of a qualified School Nurse. I will notify the school immediately and submit a new authorization form if there are ANY changes in the treatment and/or prescribing authorized health care provider.

Parent/Guardian Signature: Date:

Telephone: (Work) (Home) (Other)

AUTHORIZED HEALTH CARE PROVIDER REQUEST FOR TREATMENT

Treatment: Routine Seizure Care

Time schedule and/or indication:

Precautions, possible untoward reactions, and recommend intervention(s):

Nursing practice standards will be used for the above stated treatment UNLESS there are specific modifications or recommendations needed as checked below:

() a. Implement the treatment using nursing practice standards along with the following modifications:

() b. Implement the treatment using nursing practice standards along with my attached recommendations.

Authorized Health Care Provider Signature:

Provider NPI#:

Telephone:

Date of Request:

Date to Discontinue Treatment:



Office Stamp

SCHOOL USE:

Reviewed by: Date:

This request is valid for a maximum of one year.



ROUTINE SEIZURE CARE

I. GENERAL INFORMATION

- A. This procedure has been developed in accordance with the American Epilepsy Society's guidelines for routine seizure care. Students may have more specific plans of care designated in their Individualized School Healthcare Plans.
- B. A seizure is a brief disruptive discharge of electrical impulses in the brain. It can affect the whole brain and disrupt consciousness, or just part of the brain, in which case consciousness may or may not be affected.
- C. Signs and symptoms vary according to the type of seizure a person experiences. Certain parts of the brain control different body functions. The function of the body that is affected is related to the part of the brain involved in the seizure.
- D. The International Classification of Seizures identifies two major groupings (generalized and partial) of seizures and over thirty different types of seizures. The most common seizure types seen are described below. For further information, refer to the ***Resource Section*** of this manual.
 - 1. Generalized
 - i. Tonic-clonic seizure (Grand Mal): Loss of consciousness accompanied by falling, stiffening and jerking movements (average time is 1 – 3 minutes); breathing is shallow or absent; and skin possibly pale or bluish. Refer to the ***ROUTINE SEIZURE CARE*** procedure.
 - ii. Absence seizure: Brief lapses of consciousness (1 to 4 seconds, like daydreaming) that begin and end abruptly. No first aid needed; reassure student and give support. Repeat classroom information that may have been missed.
 - 2. Partial
 - i. Partial seizure: Consciousness unimpaired; uncontrollable changes in mood, sensation, and/or movement (such as twitching of a body part). If first aid needed, refer to the ***ROUTINE SEIZURE CARE*** procedure.
 - ii. Complex partial seizure: Impaired consciousness accompanied by confusion and uncontrollable automatic movements (such as wandering about, touching things, etc). May strike out if abruptly restrained. Lack of responsiveness may be misinterpreted as a behavior problem. Refer to the ***ROUTINE SEIZURE CARE*** procedure.
- E. Status Epilepticus can occur when there is a series of seizures without complete recovery in between or a single seizure lasting more than thirty minutes. During a prolonged convulsive seizure, depletion of oxygen, blood flow, and nutrients to the brain occurs. Each student's physician needs to define what would represent a status seizure for that particular student.
- F. Regular use of medication controls seizures in the majority of cases. Rectal medication may be ordered in case of a status seizure. The parent/careprovider

must immediately report to the school nurse any medication changes at home or school. If medication is required at school, *Parent/Guardian and Physician Request for Medication* must be completed.

- G. Parent/careprovider must complete the **Seizure History** form to assist the school nurse in developing an ISHP.
- H. Procedure will be fully discussed with parent/careprovider. Notify parent/careprovider and school nurse of seizure activity.

II. PERSONNEL

- A. School nurse.
- B. Designated school personnel in accordance with CEC 49423.5.



ROUTINE SEIZURE CARE

Student's Name: _____ DOB: _____

PROCEDURE	
ESSENTIAL STEPS	KEY POINTS & PRECAUTIONS
<ol style="list-style-type: none"> 1. Keep calm. 2. Provide reassurance and emotional support to the student as needed. 3. If student is in a wheelchair and a tonic-clonic seizure occurs, take the student out of the wheelchair unless they are determined to be safer in the wheelchair. Assist student to a side-lying position to keep airway clear and clear from all secretions. Loosen student's clothing. Remove student's glasses. 4. Clear the area around the student so that student does not get injured on hard or sharp objects. Place padding under head to prevent injury. 	<p>The student is usually not suffering or in danger.</p> <p>Determinants include issues such as:</p> <ul style="list-style-type: none"> -fragile bone diseases -padding in the wheelchair -ability of school personnel to transfer student out of the wheelchair safely and quickly -location variability's, etc. <p>Maintain safety and supervision of other students in the classroom.</p>
<ol style="list-style-type: none"> 5. Do not restrain the student's movement. Do not force anything between the teeth or place anything in the mouth. 	<p>Restraining or objects in the mouth may cause further injury. Bleeding from the mouth may occur due to biting of the tongue during the seizure; ensure open airway.</p>
<ol style="list-style-type: none"> 6. Call 911 if the following occurs: <ol style="list-style-type: none"> a. Seizure continues for more than 5 minutes. b. Breathing is absent after muscle jerks subside. c. There is no known history of seizures. d. If there is an increase in the severity of usual seizure activity. e. Respiratory distress or injury. 	<p>Risk for aspiration may occur if a seizure occurs while student is eating or while involved in water activities. Observe for signs of respiratory distress. Notify parent/careprovider and school nurse.</p>
<ol style="list-style-type: none"> 7. Remain next to the student until consciousness is regained. Upon arousal, reassure student, reorient to surroundings, and provide comfort measures as needed. Stay with student until fully recovered. 	<p>Student may be awake but groggy. Student may require clothing change due to incontinence or emesis.</p>

ESSENTIAL STEPS	KEY POINTS & PRECAUTIONS
<p>7. Do not give anything to drink or eat during or immediately following a seizure.</p> <p>8. Allow a rest period (e.g., 10 to 30 minutes), then encourage the student to resume regular activities if he/she is able.</p> <p>9. Document seizure activity on the <i>Seizure Record</i>.</p>	<p>Student should be fully awake and able to swallow before eating/drinking to prevent possible aspiration.</p> <p>If student is not able to resume regular activities then parent/careprovider should be called to transport student home.</p>



Orange County Department of Education
Community and Student Support Services

PARENT/GUARDIAN AND AUTHORIZED HEALTH CARE PROVIDER REQUEST FOR MEDICATION

Name of Student: _____ Birthdate: _____
School/District: _____ Teachers Name: _____ Grade/Track: _____

**PARENT/GUARDIAN REQUEST FOR THE ADMINISTRATION OF MEDICATION
PRESCRIPTION AND NONPRESCRIPTION**

California Education Code Section, 49423 allows the school nurse or other designated non-medical school personnel to assist students who are required to take medication during the school day. This service is provided to enable the student to remain in school and to maintain, or improve his/her potential for education and learning.

I request that medication be administered to my child in accordance with our authorized health care provider written instructions. I understand that designated non-medical school personnel may assist in carrying out written orders under supervision of a qualified School Nurse. I will notify the school immediately and submit a new form if there are changes in medication, dosage, time of administration, and/or the prescribing authorized health care provider. I give permission for the school nurse to exchange medication-related information with the authorized health care provider. The school nurse may counsel appropriate school personnel regarding the medication and its possible effects.

Emergency medicine such as EpiPen or inhalers may be carried by the student when recommended by an authorized health care provider and parent. Back-up medication should be kept at school for emergency use. I release the district and school personnel from civil liability if my child suffers an adverse reaction as a result of self-administering medication.

Parent/Guardian Signature: _____ Date: _____

Telephone: (Work) _____ (Home) _____

AUTHORIZED HEALTH CARE PROVIDER REQUEST FOR ADMINISTRATION OF MEDICATION

Reason for Medication: _____

Medication: _____ Dose: _____ Route: _____ Time: _____

If PRN: Amount of time between doses _____ Maximum number of doses _____

Possible medication reactions: _____

Instructions for emergency care _____

Authorized Health Care Provider Signature: _____

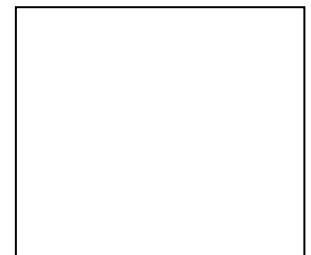
Authorized Health Care Provider Name (print clearly): _____

Telephone _____

Provider NPI # _____

Date of Request: _____

Date to Discontinue Medication: _____



Office Stamp

Regarding EpiPen/Inhalers: It is my professional opinion that this student should be permitted to carry/self administer this emergency Inhaler/EpiPen. This student has been instructed in, and demonstrates an understanding of proper usage.

Health Care Provider Initials _____

SCHOOL USE:

Reviewed by: _____ Date: _____

This request is valid for a maximum of one year.



Orange County Department of Education
Community and Student Support Services

***PARENT NOTIFICATION FOR THE
ADMINISTRATION OF MEDICINE AT SCHOOL***

Name of Student: _____

TO THE PARENT/GUARDIAN:

Medical treatment is the responsibility of the parent/guardian and an authorized health care provider. An authorized health care provider is an individual who is licensed by the State of California to prescribe medication. **Medications, both prescription and over the counter**, may be given at school when it is deemed absolutely necessary by the authorized health care provider that the medication be given during school hours. **The parent/guardian is urged, with the help of your child's authorized health care provider, to work out a schedule of giving medication at home whenever possible.**

California Education Code, Section 49423 allows school personnel to assist in carrying out an authorized health care providers written orders. Designated non-medical school personnel may be assisting with your child's medication. They will be trained and supervised by credentialed school nurses. Medication will be safely stored and locked or refrigerated, if required.

Emergency medicine such as EpiPens or inhalers may be carried by the student **when recommended by a authorized health care provider and parent**. When appropriate, the school nurse will evaluate the student's ability to safely self-administer the medication based on written district guidelines. (Title 5). Back up medication should be kept at school for emergency use. Students who have a serious medical condition (diabetes, epilepsy, etc.) should have an emergency supply of their prescription medication at school with the appropriate consent forms in the event of a disaster.

**IF MEDICATION IS TO BE ADMINISTERED AT SCHOOL, ALL OF THE FOLLOWING
CONDITIONS MUST BE MET:**

1. A written statement signed by the licensed authorized health care provider/dentist specifying the reason for the medication, the name, dosage, time, route, side effect; and specific instructions for emergency treatment must be on file at school.
2. A signed request from the parent/guardian must be on file at school.
3. Medication must be delivered to the school by the parent/guardian or other responsible adult.
4. Medication must be in your child's original, labeled pharmacy container written in English.
5. All liquid medication must be accompanied by an appropriate measuring device.
6. If pill splitting is required to obtain the correct dose of medication to be administered, only pills that are scored may be split, scored pills may be split in half only, and a commercial pill splitting device should be used for correct splitting.
7. Over the counter medication that has been prescribed by an authorized health care provider must be in its original container.
8. A separate form is required for each medication.

NOTE: Whenever there is a change in medication, dosage, time, or route the parent/guardian and authorized health care provider must complete a new form. Please discuss your authorized health care provider's instructions with your child, so that he/she is aware of the time medication is due at school.

This request is valid for a maximum of one year.