



VICTOR VALLEY UNION HIGH SCHOOL DISTRICT

Health Services
16350 Mojave Drive, Victorville, CA 92395-3655
(760) 955-3201 ext. 10427

VICTOR VALLEY UNION HIGH SCHOOL DISTRICT

Forma de información de convulsiones de un estudiante

Nombre del (de la) estudiante: _____ # ID: _____

Tipo de convulsión: _____

Fecha de la última convulsión: _____

¿Con qué frecuencia ocurren las convulsiones?: diaria ___ semanal ___
mensual ___ anual ___

Por favor describa cómo es la convulsión: _____

¿Qué es lo que posiblemente causa la convulsión?:

Existe algún tipo de advertencia y/o cambio de comportamiento antes de convulsionar?: _____

Tiempo promedio que duran las convulsiones: _____

Tiempo promedio de la recuperación: _____

Medicamento que toma el/la estudiante: Nombre, dosis, frecuencia:

Firma del padre / tutor: _____ Fecha: _____

Plan de Acción para Convulsiones

Teléf. de la escuela: 760-955-3201

Fax de la escuela: 760-257-1010

Este alumno esta siendo tratado debido a un trastorno convulsivo. La siguiente información puede asistirlo en caso de que sufra una convulsión en horas de escuela o durante actividades escolares.

Nombre del Alumno:

FDN:

Escuela:

Padre/Tutor:

Teléf. de Casa:

Celular:

Médico Principal:

Teléfono:

Fax:

Neurólogo:

Teléfono:

Fax:

El médico llena la información presentada a continuación

Historial médica relevante:

[Información sobre Convulsiones

Tipo de Convulsión	Duración	Frecuencia	Descripción	Fecha del ultimo episodio
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Que la provoca o signos de alerta: _____

Respuesta del alumno después de la convulsión:

Respuesta ante una convulsión – BÁSICA

- Mantenga la calma y tome nota del inicio de la convulsión
- Mantenga al niño seguro, PERO NO lo contenga
- No introduzca nada en su boca
- Permanezca con el niño hasta que este completamente consciente
- Documente la hora en la que finalizó la convulsión y tipo de crisis

Información del Alumno Adicional Individual

¿El padre pide que se le informe después de cada convulsión? Sí No¿Necesita el alumno dejar el aula después de una convulsión? Sí No

Si es Sí, describa el proceso para regresar al niño al aula: _____

Respuesta adicional para una convulsión tónico-clónica: • Proteja la cabeza del niño • Coloque al niño de lado • Mantenga las vías respiratorias abiertas • Vigile la respiración

En caso de incontinencia, el padre debe proporcionar un cambio de ropa a la escuela para que el niño pueda regresar al aula de acuerdo al proceso permitido anteriormente descrito: Sí No

Respuesta ante una convulsión – EMERGENCIA

 Llame al 911 Comuníquese con la enfermera de la escuela Administre los medicamentos de emergencia si se indique a continuación Avise a los padres o contactos de emergencia (arriba indicados) Avise a los médicos arriba indicados Otro:

Para este alumno, una "emergencia convulsiva" se define adicionalmente como: _____

Una Convulsión es Generalmente Considerada una Emergencia Cuando:

La convulsión (tónico-clónica) dura más de 5 minutos

El alumno sufre convulsiones recurrentes sin recordar el conocimiento

La persona (alumno) esta lastimada, tiene diabetes, o esta embarazada

Es la primera vez que el alumno se convulsiona

El alumno tiene dificultad para respirar

El alumno se convulsiona mientras esta en el agua

Protocolo para Tratamiento Durante Horas de Escuela o Actividades Escolares (incluyendo medicamentos diarios y de emergencia*)

*¿Medicamento de Emergencia?

* Nombre de Medicamento

Dosis y Horario

Efectos Secundarios Comunes e Instrucciones Especiales

 Sí No Sí No¿Tiene el alumno un Estimulador del Nervio Vago (VNS)? Sí No, Si es Sí, describa el uso del generador:

Llame al 911 si sigue convulsionándose después de haber deslizado _____ veces el imán por encima del VNS. Espere _____ minutos entre cada estimulación. Deslice el imán por encima del VNS _____ veces antes de cualquier medicamento de emergencia.

Consideraciones especiales y precauciones (referente a actividades escolares, deportes, paseos, uso de casco, o viajar en autobús después de una convulsión etc.

Describa cualquier consideración especial o precauciones: _____

Nombre del Médico:

Firma del Médico:

Fecha:

Yo doy mi consentimiento para que el personal de la escuela se comunice con el médico para consulta o intercambio de información según se requiera.

Firma del Padre o Tutor

Fecha:

Número de Teléfono:

Este formulario debe renovarse anualmente o al haber cualquier cambio en tratamiento o medicamento.

Cualquier formulario de Autorización de Medicamento es requerido y debe llenarse al igual que el Plan de Acción para Convulsiones si el medicamento se requiere en la escuela o actividades escolares.

* Cualquier formulario de Autorización de Medicamento del Médico debe completarse junto con este Plan de Acción.

Seizure Action Plan

School Phone # 760-955-3201
School Fax # 760-257-1010

This student is being treated for a seizure disorder. The information below may assist if a seizure occurs during school hours or at school activities.

Student Name: _____ **Date of Birth:** _____ **School:** _____
Parent/Guardian: _____ **Home Phone:** _____ **Cellular:** _____
Primary Physician: _____ **Phone:** _____ **FAX:** _____
Neurologist: _____ **Phone:** _____ **FAX:** _____

Physician completes form from this point forward.

Significant Medical History: _____

Seizure Information

Seizure Type	Length	Frequency	Description	Last Seizure Date

Seizure triggers or warning signs: _____

Student's response after seizure: _____

Seizure Response - BASIC

- Stay calm and record start of seizure
 - Keep child safe but Do NOT restrain
 - Do not put anything in mouth
 - Stay with child until fully conscious
 - Document ending time and description of seizure
- Tonic-clonic seizure additional response:**
- Protect child's head
 - Turn child on side
 - Keep airway open
 - Monitor breathing

Additional Individual Student Information:

Parent requests notification after each seizure Yes No
 Does student need to leave the classroom after a seizure? Yes No
 If YES, describe process for returning student to classroom: _____

In case of incontinence, parent should provide extra clothing for school so student may return to class as allowed by process above. Yes No

Seizure Response - EMERGENCY

- Call 911 for paramedics
- Contact school nurse
- Administer emergency medications if indicated below
- Notify parents or emergency contact (as listed above)
- Notify doctor listed above
- 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, has diabetes, or is pregnant
- Student has a first-time seizure
- Student has breathing difficulties
- Student has a seizure in water

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

Treatment Protocol During School Hours or School Activities (Include daily and emergency medications*)

*Emergency Medication?	*Medication Name	Dosage and Time of Day Given	Common Side Effects and Special Instructions
<input type="checkbox"/> Y or <input type="checkbox"/> N			
<input type="checkbox"/> Y or <input type="checkbox"/> N			

Does student have a Vagus Nerve Stimulator? Yes No, if YES, describe magnet use: _____

Call 911 if still seizing after _____ VNS swipes. Wait _____ minutes between swipes. Give _____ swipes before any emergency medication.

Special Considerations and Precautions (regarding school activities, sports, trips, helmet use, or bus riding after seizure, etc.)

Describe any special considerations or precautions: _____

Physician Name: _____ **Physician Signature:** _____ **Date:** _____

I give permission for school staff to contact the physician for consultation and exchange of information as needed.

Signature of Parent or Guardian: _____ **Date:** _____ **Phone Number:** _____

This form must be renewed annually or with any change in treatment or medication.

The Medication Administration Form must be completed in addition to the Seizure Action Plan if medication is required at school or school activities.

* Medication Administration Form Required

School Phone # 760-955-3201
School Fax # 760-257-1010

PHYSICIAN INSTRUCTIONS

For SCHOOL ASSISTED MEDICATION

A. This form must be completed before any medication (*prescription or over-the-counter*) can be given, or taken, at school.
Signatures of both physician and parent/guardian are required. This form must be renewed annually or with any change in medication.

Student Name: _____ Date of Birth: _____

PHYSICIAN USE ONLY

1. MEDICATION: _____ Dose: _____ Reason/Diagnosis: _____

Route: Oral Nasal Topical
 Inhale Injection Other _____ Med Start Date: _____ Stop Date: _____

If DAILY ~ Time(s) to be given: _____

If AS NEEDED (prn) ~ Frequency: Every 3 to 4 hrs., Every 4 to 6 hrs., Other : _____

*Self carry – for asthma inhaler or epinephrine auto-injectors ONLY. Student demonstrates competence.
o (Not recommended in elementary school)

Other instructions if needed (e.g., signs/symptoms for usage, special storage, adverse reactions): _____

2. MEDICATION: _____ Dose: _____ Reason/Diagnosis: _____

Route: Oral Nasal Topical
 Inhale Injection Other _____ Med Start Date: _____ Stop Date: _____

If DAILY ~ Time(s) to be given: _____

If AS NEEDED (prn) ~ Frequency: Every 3 to 4 hrs., Every 4 to 6 hrs., Other : _____

*Self carry – for asthma inhaler or epinephrine auto-injectors ONLY. Student demonstrates competence.
o (Not recommended in elementary school)

Other instructions if needed (e.g., signs/symptoms for usage, special storage, adverse reactions): _____

Physician Signature: _____ Date: _____

Physician Name: _____

Address: _____ Phone: _____

City: _____ Zip: _____

All medication orders will be automatically discontinued at the end of the school year. New orders are required each school year.

California Education Code section 49423 provides that any pupil who is required to take, during the regular school day, medication prescribed for him by a physician, may be assisted by the school nurse or other designated school personnel if the school district receives (1) a written statement from such physician detailing the method, amount, and time schedules by which such medication is to be taken and (2) a written statement from the parent or guardian of the pupil indicating the desire that the school district assist the pupil in the matters set forth in the physician's statement.

* California Education Code section 49423 (c) A pupil may be subject to disciplinary action pursuant to Section 48900 if that pupil uses an inhaler or auto-injectable epinephrine in a manner other than as prescribed.

**Parent Request
For Assistance with Medication at School**

B. The parent or guardian must complete this page before any medication (*prescription or over-the-counter*) can be given, or taken, at school.
Signature of parent or guardian is required. This form must be renewed each school year or with any change in medication.

Student Name: _____ **Date of Birth:** _____

Parent Request for School Assistance with Medication

I understand that school district regulations require student medication to be maintained in a secure place, under the direction of an adult employee of the school district, and not carried on the person of a student (with the exception of asthma inhalers and epinephrine auto-injectors accompanied by appropriate physician instructions).

A. I hereby request that the staff of my child's school assist in giving medication to my child during school hours as stated in the physician instructions. I also give permission to contact the physician for consultation and exchange of information as needed.

Parent or Guardian Signature: _____ **Date:** _____ **Phone Number:** _____

B. For **ASTHMA INHALER/EPINEPHRINE AUTO-INJECTOR SELF-CARRY** requests only: I hereby request that my student carry and self-administer his/her asthma inhaler or auto-injector. I understand that if my student does not follow the rules and responsibilities of carrying his/her medication, he/she will lose the privilege of carrying such medication.* I also give permission to contact the physician for consultation and exchange of information as needed.

Parent or Guardian Signature: _____ **Date:** _____ **Phone Number:** _____

Student Contract – Asthma Inhalers Only

I agree to keep my medication in a safe and secure place, such as on my person, at all times. I agree I will NEVER share my medication with another student. If I am using my inhaler more than once a day, or several times a week, I will speak with the school nurse.

Student Signature: _____ **Date:** _____

Parent Signature: _____ **Date:** _____

All medication orders will be automatically discontinued at the end of the school year. New orders are required each school year.

* California Education Code section 49423 (c) A pupil may be subject to disciplinary action pursuant to Section 48900 if that pupil uses an inhaler or auto-injectable epinephrine in a manner other than as prescribed.



Authorization for Use and/or Disclosure of Information

STUDENT INFORMATION

Student Name: _____ Date of Birth: _____
 School Site: _____ LEA of Residence: _____
 Street Address: _____ City: _____ State: _____ Zip Code: _____
 Home Phone: _____ Cell Phone: _____ E-mail Address: _____

AUTHORIZATION

I authorize the individual/agency named below to disclose the above-named student's medical and/or educational information to the receiving LEA as indicated under this Authorization.

DISCLOSING AGENCY

Individual/Agency DISCLOSING Information: _____
 Street Address: _____ City: _____ State: _____ Zip Code: _____
 Contact Name: _____ Phone: _____ E-mail Address: _____

RECEIVING AGENCY

Individual/Agency RECEIVING Information: Victor Valley Union High School District
 Street Address: 16350 Mojave Drive City: Victorville State: Ca Zip Code: 92395
 Contact Name: Julie Dieppa, RN Phone: 760-955-3201 Ext. 10427 E-mail Address: jdieppa@vvhhsd.org

I agree that the Individuals/Agencies above may mutually share information.

INFORMED CONSENT (INITIAL EACH STATEMENT BELOW)

_____ **REVOCATION:** I understand that I have the right to revoke this Authorization, in writing, at any time by sending such written notification to the releasing agency. Written revocation will be effective upon receipt, but will not apply to information that has already been released in response to this Authorization.

_____ **REDISCLASURE:** I understand that educational health information used or disclosed pursuant to this Authorization may be subject to redisclosure by the recipient and it is no longer protected by federal laws and regulations regarding the privacy of protected health information. I further understand the confidentiality of the information when released to a public educational agency is protected as a student record under the Family Educational Rights and Privacy Act (FERPA).

_____ **HEALTH INFORMATION:** I understand that authorizing the disclosure of health information is voluntary. I can refuse to sign this Authorization. I do not need to sign this form in order to assure medical treatment.

SPECIFY RECORD(s):

- Medical/Medication Mental Health/Psychiatric Drug/Alcohol
 Educational Records STD/HIV Test Results Other: _____

DURATION: This authorization shall become effective immediately and shall remain in effect until _____ (Date)
 or for one year from the date of signature if no date is entered.

I request that the information released pursuant to this Authorization be used for the following purposes:
 Educational Assessment Educational Planning Other: _____

A COPY OF THIS AUTHORIZATION IS AS VALID AS AN ORIGINAL. I UNDERSTAND THAT I HAVE A RIGHT TO RECEIVE A COPY OF THIS AUTHORIZATION FOR MY RECORDS.

Parent/Guardian Signature: _____ Date: _____
 Student Signature: (if applicable) _____ Date: _____