



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

Student Seizure Information Sheet

Student name: _____ ID: _____

Seizure type: _____

Date of last seizure: _____

How often seizures occur: daily ___ weekly ___ monthly ___ yearly ___

Describe what seizure looks like: _____

Possible triggers: _____

Possible warning and/or behavior changes prior to the seizure:

Average length of time seizures last: _____

Average length of time for recovery: _____

Medications student takes: Name, dose, frequency:

Parent/Guardian Signature: _____ Date: _____

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: _____

<p>Seizure Response – BASIC</p> <ul style="list-style-type: none"> ▪ 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 <p>Tonic-clonic seizure additional response: • Protect child's head • Turn child on side • Keep airway open • Monitor breathing</p>	<p>Additional Individual Student Information:</p> <p>Parent requests notification after each seizure <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Does student need to leave the classroom after a seizure? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If YES, describe process for returning student to classroom: _____</p> <p>In case of incontinence, parent should provide extra clothing for school so student may return to class as allowed by process above. <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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<p>Seizure Response – EMERGENCY</p> <p><input type="checkbox"/> Call 911 for paramedics</p> <p><input type="checkbox"/> Contact school nurse</p> <p><input type="checkbox"/> Administer emergency medications if indicated below</p> <p><input type="checkbox"/> Notify parents or emergency contact (as listed above)</p> <p><input type="checkbox"/> Notify doctor listed above</p> <p><input type="checkbox"/> Other: _____</p>	<p>A Seizure is Generally Considered an Emergency When:</p> <p>Convulsive (tonic-clonic) seizure lasts longer than 5 minutes</p> <p>Student has repeated seizures without regaining consciousness</p> <p>Student is injured, has diabetes, or is pregnant</p> <p>Student has a first-time seizure</p> <p>Student has breathing difficulties</p> <p>Student has a seizure in water</p>
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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)

REVOCACTION: 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: _____