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: _____

Seizure Action Plan

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**

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

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

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:

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:

Una Convulsión es Generalmente Considerada una Emergencia Cuando:

La convulsión (tonicoclónica) dura más de 5 minutos

umno su re convu siones recurren es sin reco rar e 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

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

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 comunique 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
☐ Y or ☐ N			
☐ Y or ☐ 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.**
- (**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.**
- (**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.

Victor Valley Union High School District
Health Services
16350 Mojave Drive Victorville, CA 92395
760-955-3201 ~ 760-257-1010 Fax

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 the receiving LEA as indicated under the Authorization.

DISCLOSING AGENCY

Individual/Agency DISCLOSING Information:_____

Street Address: _____ City: _____ State:_____ Zip Code:_____

Contact Name:_____ Phone:_____ Email Address:_____

RECEIVING AGENCY

Individual/Agency RECEIVING Information:_____

Street Address: _____ City: _____ State:_____ Zip Code:_____

Contact Name:_____ Phone:_____ Email Address:_____

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

INFORMED CONTENT (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 will be effective upon receipt, but will not apply to information that has already need released in repose to this Authorization.

_____ **REDISCLOSURE:** 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 release to a public educational agency is protected as a student records 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 _____, or for one year from the date of signature if no date is entered.

I request that the information release 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 THE RIGHT TO RECEIVE A COPY OF THIS AUTHORIZATION FOR MY RECORDS.

Parent/Guardian Signature: _____ **Date:** _____

Student Signature: (*if applicable*) _____ **Date:** _____