PRINCE GEORGE COUNTY PUBLIC SCHOOLS

Seizure Disorder Health Care Plan and Medication Administration Authorization

Student's Name: _____ DOB: _____ School: _____

Medication Allergies: _____ School Year: _____

♥ TO BE COMPLETED BY PHYSICIAN OR LICENSED PRESCRIBER ♥

Seizure Type(s): _____ Aura/Type: _____

Frequency: _____ Duration: _____

List any special considerations, equipment, activity restrictions, treatments or special diet required at school related to seizure disorder:

_____

_____

Medication(s) given at home: _____

MEDICATION(S) TO BE ADMINISTERED DURING SCHOOL HOURS BY SCHOOL PERSONNEL FOR CONTROL OF SEIZURES:

Prescription: Medication: _____

Dosage, Time, Route: _____

Duration: _____ Date of Prescription: _____

Possible Side Effects: _____

Prescription: Medication: _____

Dosage, Time, Route: _____

Duration: _____ Date of Prescription: _____

Possible Side Effects: _____

Signs of seizure activity may include: staring/visual disturbance, unusual smell/tastes, stiffening of arms and legs followed by rhythmic jerking with or without unresponsiveness, shallow breathing, drooling, bluish skin, and loss of bladder or bowel control.

If seizure activity occurs, provide the following measures:

- Remain calm. No one can stop a seizure once it starts.
- An adult should remain with the student. Provide privacy.
- Protect student's head from injury by placing folded blanket, towel or jacket under head.
- Assist student to lie down on his/her side to keep airway clear.
- Loosen collar if needed.
- **Do not** attempt to hold down or restrain student's movements. (This may cause fractures or bruising)
- **Do not** place objects, food, drink or medication in mouth. (This may cause aspiration, vomiting, broken teeth, bitten tongue)
- **Do not** move student if injury has occurred.
- **Administer medication as prescribed above.**
- Document seizure activity to include: date, time seizure began, area of body where seizure began, loss of bladder or bowel control, and type of movement of head, face or arms.
- Notify principal and parent/guardian. **(Refer to bottom of page 2 for emergency contact phone numbers)**
- **CALL 911 for ANY of the following**:
  - ❖ Seizure **lasts more than 5 minutes.**
  - ❖ Two or more consecutive seizures occur.
  - ❖ More seizures than usual or change in type of seizure.
  - ❖ Student stops breathing or does not have a pulse. (Perform CPR if required)
  - ❖ Student is diabetic or pregnant.
  - ❖ There is evidence of injury or seizure occurs in water.
  - ❖ Student cannot be awakened, pupils are not equal in size and/or vomits continuously **after seizure has ended**.
- Other: _____

After a seizure is over, monitor student's breathing and allow rest for at least 30 minutes. Orient student to surroundings.

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE MY CHILD TO MEDICAL FACILITY!

Parent/Guardian Signature _____ Date _____

Physician/Prescriber Signature _____ Date _____

Physician/Prescriber PRINTED Name _____ Phone _____ FAX _____

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♥ TO BE COMPLETED BY PARENT / GUARDIAN ♥

Student's Name: _____ School: _____ Teacher: _____

Age of onset of seizures: _____ Date of last seizure: _____ Time/length of seizure:_____

Describe your child's seizure:_____

_____

How many times has your child been seen in the emergency room for seizures in the last year? _____

Date your child was last seen by a physician for evaluation/follow-up for seizure disorder:_____

List any known triggers for seizure activity:_____

_____

List any warning signs and/or behavioral changes that may indicate a seizure is about to occur:_____

_____

Plan for field trips:

Parent will attend: _____YES _____NO

In the absence of the parent, the principal's designee who has been trained in administration of medication and measures to follow in the event of a seizure will attend the field trip to provide care and administer medication (if prescribed).

Other:

Plan for transportation to and from school:

The Transportation Department will be informed of student's seizure condition and has radio communication with bus drivers.

Other:

Plan for instructing administration and instructional staff:

School nurse will share seizure disorder health care plan information with administration and instructional staff.

A registered nurse will provide training in administration of medication (if prescribed) and measures to follow in the event of a seizure to unlicensed personnel designated by the principal to provide care and administer medication in the absence of the nurse.

Other:

Plan for notifying substitutes:

Teacher is responsible to share seizure disorder health care plan information with substitutes.

Additional Instructions:

EMERGENCY CONTACTS: Name/Relationship **Phone Number(s)**

a. _____ 1.) _____ 2.) _____

b. _____ 1.) _____ 2.) _____

c. _____ 1.) _____ 2.) _____

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I, _____, parent or legal guardian of _____, request that the principal's designee at _____ School administer the prescribed medication and provide care to my child as indicated on the *Seizure Disorder Health Care Plan* dated _____. I give the principal's designee permission to contact the licensed prescriber if necessary. In signing this form, I am agreeing to hold the school and its personnel free from any legal action that might arise from this arrangement.

I also understand that I am to abide by the school division regulations as stated below:

- It is my child's responsibility to come to the clinic to take his/her medication.
- Parent or guardian must bring medication into school office or clinic. Medication cannot be transported on buses or by students.
- The first dose of a new medication should be given at home.
- Prescription medication must have a current prescription label that corresponds with the written authorization.
- Any changes in a medication require a new written authorization and corresponding change in the prescription label.
- Parent or guardian must provide medications/equipment required to administer medications or provide special medical care.
- Left over medication must be picked up at the end of the school year or it will be discarded.

I approve this *Seizure Disorder Health Care Plan* for my child. I give permission to share information about my child's seizure disorder with the school nurse, teachers, principals, office staff, guidance, bus driver/transportation and cafeteria manager as appropriate. I give the principal or his designee the authority to call the rescue squad or take my child to a hospital emergency room in case of emergency.

Parent/Guardian Signature _____ Date _____

Parent/Guardian PRINTED Name _____

Home Phone _____ Work Phone _____ Cell Phone _____

School Use:

Health care plan information provided by _____ to the following staff:

Names of Persons and Date	*Names of Persons and Date*
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Staff members trained to administer medication and assist with this student's care at school in the absence of the nurse:

Name of Person	*Location or Room Number*	*Date Trained*
1. _____		
2. _____		
3. _____		
4. _____		
5. _____		