Dear Parent / Guardian,

Our school records show that your student has a history of Seizures. Please complete the forms provided and return them, as soon as possible, to the school nurse. Please note: new forms are required every school year.

1. Seizure Action Plan (HEA-F120). This document is to be completed by the parent/guardian even when no medications are required at school. If medications(s) will be required at school, then the physician must also complete.

2. Authorization for Medication To Be Taken During School Hours (HEA-F062). A separate form is required for each medication that the physician is asking to be administered at school. This would include oral medication, Diastat and other medication that might be necessary at school if your child were to have a seizure. Please note: The school nurse will notify the parent/guardian, at least one (1) month prior to the expiration date of each medication, when new anti-seizure medication will be required. This medication needs to be in the original package, the dosage locked in by the dispensing pharmacy, with an intact label and valid expiration date.

3. Notification of Parent-Administered Medication Outside of School Hours (HEA-F093) **(PLEASE KEEP THIS FORM TO MAKE COPIES AS NEEDED)**
   It is the parent/guardian's responsibility to notify the school nurse in writing, of the administration of any anti-seizure emergency medication, new prescription or over-the-counter medication while at home. Diastat is not to be used more than once in 5 days according to manufacturer's dosing recommendations and new or over-the-counter medications can change how the student's regular medications work.

We greatly appreciate your time and effort in completing these forms. This is another step in keeping your student safe while getting the best possible education at school. Please feel free to contact your school nurse if you would like to discuss your student's condition or need assistance completing these forms.

SEIZURE ACTION PLAN

Student's Name:_____ Date of Birth:_____
School:_____ Teacher:_____
Treating Physician:_____ Physician Phone: _____
Significant medical history:_____

EMERGENCY CONTACT INFORMATION:

Name	*Relationship*	*Phone # 1*	*Phone # 2*
1.			
2.			

SEIZURE INFORMATION:

Seizure Type	*Length*	*Frequency*	*Description (what does it look like?)*

Seizure triggers or warning signs:_____

Student's reaction to seizure:_____

Will your student have any special activity adaptations/protective equipment (e.g. helmet) at school? NO / YES

If yes, explain:_____

Is the student allowed to participate in physical education and other school trips and activities? NO / YES

Explain/give details:_____

Does student need to leave the classroom after a seizure? NO / YES

Describe process for returning to classroom:_____

_____

A Seizure is generally considered an Emergency when:

- ✓✓ A convulsive (tonic-clonic) seizure lasts longer than 5 minutes
- ✓✓ Student has repeated seizures without regaining consciousness
- ✓✓ Student has a first time seizure
- ✓✓ Student is injured or has diabetes
- ✓✓ Student has breathing difficulties
- ✓✓ Student has a seizure in water

EMERGENCY RESPONSE:

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

_____

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

- ☐ Contact school nurse at_____
- ☐ Call 911 for transport to_____
- ☐ Notify parent or emergency contact
- ☐ Notify doctor
- ☐ Administer emergency medications as indicated below
- ☐ In absence of nurse or trained volunteer call 911 at onset of seizure
- ☐ Other_____

Basic Seizure First Aid

- Stay calm & track time
- Keep child safe
- Do not restrain
- Do not put anything in mouth
- Stay with child until fully conscious
- Record seizure information

For Tonic-Clonic Seizure

- Protect head
- Keep airway open/watch breathing
- Turn child on side

TREATMENT PROTOCOL DURING SCHOOL HOURS: (include daily and emergency medications)

Daily Medication	Dosage & Time of Day Given	Common Side Effects & Special Instructions

Emergency Medication	Dosage/Route	When to use	Can it be repeated (if yes, when)

Does student have a **Vagus Nerve Stimulator (VNS)**? YES NO
If YES, Describe magnet use_____

Physician Signature:_____ **Date:**_____

Parent Signature:_____ **Date:**_____

AUTHORIZATION FOR MEDICATIONS TO BE TAKEN DURING SCHOOL HOURS

PLEASE NOTE **:** Medications must be brought to and picked up from school by a parent/guardian or his/her adult designee. Children may not bring medication to school or take medication home unless it is an emergency rescue medication that must remain with the student at all times. Prescription Medication must be in a properly labeled prescription bottle with the student's name, pharmacy name and phone number, date (within current school year), prescriber's name, name of medication, dose and frequency imprinted on the pharmacy label. Over the Counter Medication must be in the manufacturer's original and unopened container which shows a list of ingredients.

The following section is to be completed by the PARENT/GUARDIAN:

School:	**Student's Name:**	**Date of Birth:**

I request that my child be assisted in taking medication, described below, at school by legally authorized persons or permitted to medicate himself/herself as also authorized by my child's physician. I also give my permission for school personnel to contact my child's physician. I understand that in a health or safety emergency involving my child, school officials may share confidential health information to appropriate and necessary health, safety or welfare officials.

I, _____, will assume any and all responsibility and liability for any problems

Parent/Guardian's Printed Name

with my child taking this medication at school. I release CMCSS and its personnel from any legal claims which they have now, or thereafter have, arising out of medication taken while at school.

_____ _____ (____)_____ (____)_____

Date **Parent/Guardian Signature** **Home Phone** **Emergency Phone**

The following section is to be completed by the PHYSICIAN for prescription medications or by PARENT/GUARDIAN for Over the Counter Medications

Name of Medication:

Diagnosis for which medication is prescribed:

Route:	**Dose:**

If medication is to be given daily, at what time? (please consider alternate dosing schedule to minimize medication in school)

If medication is to be given "when needed" describe indications:

How soon can it be repeated?	**Length of time treatment recommended?** **___Current School Year ___Other:_____**

List significant side effects:

Provider to initial yes or no for each of the following:

Is student permitted to carry and self-administer emergency rescue medication? **_____ YES _____ NO**

Has student been instructed in self administration of prescribed rescue medication? **_____ YES _____ NO**

Date **Physician's Signature**

Physician's Name, Address and Phone Number:

CLARKSVILLE-MONTGOMERY COUNTY SCHOOL SYSTEM

NOTIFICATION OF PARENT-ADMINISTERED EMERGENCY SEIZURE MEDICATION OUTSIDE OF SCHOOL HOURS

1.) Pursuant to TCA, Section 49–5-415, subsection (g): and TN State Department of Health and Department of Education Guidelines, it is the responsibility of the student's parent/guardian to notify the school nurse and/or the school administrator in writing of the administration of any anti-seizure emergency medication or any medication that is not in the regular medication schedule. This is because **emergency seizure medications should not be given more than once in a specific amount of time depending on the medication.** New or over-the-counter medications may also change how the child's regular medications work.

2.) The school system cannot be held liable for any adverse reactions that a student has, but especially when knowledge of new medications or emergency medications that are given at home is not shared with the school nurse or school administrator by the first day the student returns to school following home medication administration.

3.) This form should be completed by the parent or guardian to record when these emergency seizure medications are given outside of school and returned to the school nurse. Parent/Guardian will provide the following information:

If more than one medication is administered use a new form for each.

Is the medication a prescription medication? _____Yes _____No

Is the medication an over-the-counter medication/herbal supplement? _____Yes _____No

Name of the medication_____

The amount of medication given_____

The time and date the medication was given_____

The route of administration _____

The reason the medication was given_____

_____

Has the student taken this medication before? _____ Yes _____ No

Was the medication given more than one (1) time? _____Yes _____No
If yes, explain the time frame for administration and why it was given more than one time.

_____

Parent signature:_____Date:_____

For School Use Only

School Personnel receiving form:_____Date:_____

Position/Title:_____Total # of Forms:_____