Dear Parent / Guardian,

Our 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 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 includes emergency medications that might be necessary if your child has a seizure at school.

We appreciate your time in completing these forms, as they are essential in ensuring your child's safety while they receive the best possible education.

If you have any questions or need assistance completing these forms, please contact your school nurse.

SEIZURE EMERGENCY ACTION/HEALTH PLAN

20 -20

Student's Name: _____ DOB: _____
School: _____Grade/Teacher: _____

EMERGENCY CONTACT INFORMATION:

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

SEIZURE INFORMATION:

Significant medical history: _____
Seizure triggers or warning signs: _____

Date of last seizure: _____Description: _____ Treatment: _____

Does student have a Vagus Nerve Stimulator (VNS)? ◯ No ◯ Yes – Where will it be kept: _____

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

Does the student have any activity restrictions? ◯ 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 emergency" for this student is defined as: _____

_____

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

SEIZURE ACTION PLAN:

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

- ☐ Note start time of seizure
- ☐ Contact school nurse at: _____
- ☐ In absence of nurse or trained volunteer call 911 at onset of seizure
- ☐ Notify parent or emergency contact
- ☐ Administer emergency medications as indicated below
- ☐ 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)

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.

Physician Signature: _____ Date: _____

Parent Signature: _____ Date: _____

Clarksville-Montgomery County School System
20____ - 20____

AUTHORIZATION FOR MEDICATIONS TO BE TAKEN DURING SCHOOL HOURS

PLEASE NOTE **:** Medications must be brought to school by a parent/guardian. Students may not self carry medication at school unless it is an emergency rescue medication that must remain with the student at all times, and is indicated by the prescriber below. 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 on the pharmacy label. Over the Counter Medication must be in the manufacturer's original and unopened container which shows a list of ingredients. Medications must be picked up by a parent/guardian at the end of the school year or they will be discarded.

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 give my permission for school personnel to contact my child's physician. I understand that in a health or safety emergency with 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, and release CMCSS and its personnel from any legal claims arising out of medication taken at school.

_____ _____ _____ (____)_____

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

PARENT APPROVAL OF SELF CARRY/SELF ADMINISTRATION OF EMERGENCY RESCUE MEDICATION ONLY (EPI, asthma relief inhaler)
Provider must indicate below and **s**elf-carry privileges may be revoked if the school nurse determines they are misusing the medication, sharing the medication, or found incapable of properly administering.
Parent intitial for emergency rescue medication only: _____ I DO _____ I DO NOT request my child be permitted to self carry and self administer emergency medication as ordered by the healthcare provider.

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 *for emergency rescue medications only:* *(EPI, relief inhalers)*
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: