Dear Parent(s)/Guardian,

Your child has medical needs that will be addressed during the school day. In preparation for the start of the school year, required forms are enclosed for your doctor and you to complete. By receiving the forms early, it is hoped that the paperwork will be completed, making the transition back to school easier.

Please fill out the parent seizure questionnaire.

With your child's Doctor please review, fill out and sign the following Seizure Health Care Plan for your child for this coming school year. The medication form is for any seizure medications needed to be given at school.

Please add the most current list of contact and contact telephone numbers, as well as your child's Doctor's name and telephone numbers. Feel free to make any changes or additions.

With no Seizure Health Care plan in place, if your child has a seizure.....the school may have to call 911 and then call the parent.

Seizure Health Care Plan and Request to Dispense Medication are on our school web-site, under Departments, Special Services, Health Services….forms are on the right side of page.

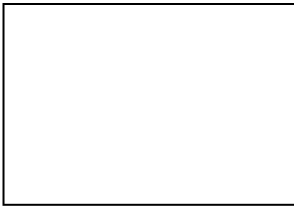
Sincerely yours,

Huber Heights City Schools
Health Services

Attachments:

____ Seizure Health Care Plan ____ HHCS Medication Form 900.42

RDB 10/20/2021



SEIZURE
HEALTH CARE PLAN

(Please complete with the help of your doctor.)

If medication is part of the seizure plan a request for medication form must be filled out

Name: ____________________________ Age: ____ Date of Birth: _____________ Grade:________

School: __________________________________ Homeroom Teacher: ______________ Room: _______

Parent/Caregiver:________________________________ Phone (home): ___________________Cell:_________________
Email____

Address: ____ Phone: (work): ___________________

*****Attach Student Emergency Health Information for additional emergency contacts*****

Doctor Treating Student for Seizure: ___________________________ Phone: _____________ Fax: ________________

IF YOU SEE THIS

Type of seizure: ____ Date of last seizure__________
Triggers which start a seizure: ____
Possible seizure signs: ____
Usual length of seizure: ____
Other: ____allergic to:

DO THIS

Call office to call nurse at start: yes/no

Give Diastat/Midazolam for seizure over: ____mins
With medication request signed by Dr. and parent
Use VNS magnet at onset yes/ no

- **Help the student to the floor, or remain in chair.**
- **Place student on side if drooling or vomiting.**
- **Clear any object out of the way.**
- **Place something soft and flat under students head.**
- **Loosen any tight clothing around neck.**
- **Monitor the student's breathing*-gently keep airway open.***
- **Stay calm!**
- **Look at the clock to see how long the seizure lasts.**
- **Stay with the student until seizure ends, comfort and allow student to rest after seizure.**
- **Student may be confused, re-orient student.**
- **Notify parents.**
- **Document what happened in student's file.**
- **If emergency seizure medication is used parent will pick up.**

Don't put anything in child's mouth.
Don't hold or restrain child.

Call 911 if ….

Seizure different or unusual from others.
You are alarmed by frequency or severity
You are alarmed by breathing or skin color
The person is having unusual or serious problems
Seizure of 5 minutes or greater duration after Diastat administered
I authorize school personnel to implement this Seizure Care Plan as described above and share with pertinent school staff. I give consent for school to communicate with my child's doctor when necessary.

____ __________________
Parent/Guardian Signature **Date**

Nurse Signature ______________________________________ __________________

Date

HUBER HEIGHTS CITY SCHOOLS

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PARENT/GUARDIAN SEIZURE DISORDER QUESTIONNAIRE

Please complete and return to the District Nurse. The following information is helpful in determining any special needs.

Student ____ DOB ________________________

School ____ Grade/Room _________________

Parent/Guardian ______________________________________ Phone ______________________

Physician ____ Phone ______________________

Hospital ____ Phone ______________________

Student's age at diagnosis of seizure disorder____

Does this student wear a medical alert bracelet/necklace? ________Yes _________No

Please check the type(s) of seizures this student has had:

______Tonic-Clonic (Grand Mal)

_______Absence (Petit Mal)

_______Complex (Psychomotor/Temporal Lobe)

_______Simple (Jacksonian/Focal Motor)

_______Febrile (with high fever)

_______Other (please describe) ____

When was this student's most recent seizure?____

How often does this student typically experience seizures? ___Daily ____Weekly ___Monthly ____Other____

How long does a typical seizure last? _____seconds ______minutes ______other

Has this student ever been treated for status epilepticus (a prolonged seizure)? ____Yes ____No

Does this student usually experience any early warning signs/symptoms before a seizure (i.e. sensory or mental auras)? _______Yes ______No

Please describe: ____

____

Does he/she recognize these signs/symptoms? _____Yes _____No

Please check your student's usually signs/symptoms of a seizure:

____loss of consciousness

____falling down

____muscle stiffness

____rhythmic convulsions

_____blank stare

_____twitching/jerking of body part

_____repetitive acts/movements

_____confusion

____purposeless activity

____aimless wandering

____fluttering eyelids

_____loss of awareness (i.e. unresponsive)

_____loss of control (bladder, bowel, drooling, etc.)

_____other

Please describe how this student acts after a seizure (i.e. drowsy, sleepy, headache, etc.)

Please check any known triggers for this student's seizure:

___bright lights

___temperature changes

___fatigue

____stress

____loud noises

____hunger

____fever

____other (please list)

____

Please list any activities that this student should avoid: ____________________________________

Please list any specific activities in which this student needs particularly close supervision: _________

____

- If a medication is to be given at school, a medication authorization form must be completed yearly. A prescribing health professional may authorize self-administration of medication if the student is deemed capable. The medication must be in the original labeled container.
- In an acute emergency, the student will be transported by paramedics to the hospital. Transportation in a non-acute situation is the responsibility of the parent/guardian. Any charges incurred are the responsibility of the parent/guardian.

Please add anything else that you would like school personnel to know about this student's seizures (or related health conditions).

Information was provided by____
(Name)

____ ___________________________
(Relationship) (Date)

I authorize reciprocal release of information related to seizures between district nurse and the physician.

____ ____________________________
(Name) (Date)

HUBER HEIGHTS CITY SCHOOLS

MEDICATION ADMINISTRATION REQUEST AT SCHOOL

Part I – TO BE COMPLETED BY PHYSICIAN

Name of Student ____________________ Date of Birth ____________

Address of Student ______________________________________

School Building __________ Principal ________ Grade ___ Teacher/Room# __________

Name of medication to be administered: ______________________________

Reason student is taking medication: ______________________________

Quantity (dosage) ________ Route _____ Times _____ Date to Begin_____ Date to End_____

Possible reaction that should be reported to physician: ______________________

Special instructions, if required (administration of drug, sterile conditions, storage, etc.) __________

YES ____ NO _____ This student may self administer for field trips-Inhalers only

Physician's Name (please print) ______________________________

Physician's Address ______________________________________
(Street) (City) (Zip Code)

NPI# ____________ Physician's Phone No. ________ Physician's Fax No. __________

Physician's Signature ______________________ Date ______________

Part II – TO BE COMPLETED BY PARENT(S), FOSTER PARENT(S), OR GUARDIAN(S) **

WE (I) understand that the administration of said medications/procedure is to be done under the supervision of a medically untrained member of the adult school staff.

FURTHER, we (I) understand that the school personnel are not legally obligated to administer medication to any child and, therefore, we (I) agree to hold the school district and any and all of its employees free from any and all responsibility for the results of such medication or the manner in which it is administered and to indemnify each of them against any loss or expense incurred arising out of these arrangements, including any civil judgment which may be rendered against them.

FURTHER, we (I) agree to deliver the medication to the school in the original container from the prescribing physician or licensed pharmacist, properly labeled by same, this label to include name of student, physician, date, dosage instructions (quantity and times), and name of medication.

FURTHER, we (I) will notify the school immediately if we change physicians or terminate the use of this medication for any reason, and we will report immediately to the school to pick up the remainder of said medication.

FURTHER, we (I) give permission for nurse to confer with physician regarding any questions regarding this medication.

FURTHER, we understand medication not picked up at end of school year will be disposed.

Signature of father or guardian ______________________ Date __________

Signature of mother or guardian ______________________ Date __________

Address ______________________________ Home Phone ______________

Work Phone: ____________ Cell Phone: ____________ E-mail: ______________

Part III – TO BE COMPLETED BY THE SCHOOL

Signature of Principal/Nurse: ______________________ Date: __________

**Both parents must sign this release if they are living with or have custody of the child. If parents are separated and both still retain legal custody, both parents must sign. If child is in a foster home and placement is by agency that holds custody, agency representative must sign.

PLEASE RETURN THIS FORM TO THE SCHOOL CLINIC