**School Year:** _____

Lexington-Fayette County Health Department

School Health
650 Newtown Pike
Lexington, KY 40508-1197
(859) 288-2314
(859) 288-2313 Fax

# EMERGENCY MEDICAL PLAN
# PARENT PACKET – SEIZURE
# DIASTAT & ORAL MEDICATIONS

Dear Parent/Guardian:

You have informed us that your student has a medical concern. Enclosed are the forms, which need to be completed by both the Parent/Guardian and student's Physician. These forms are necessary in order for the School Nurse or appropriately trained school personnel to perform or administer specific medical treatment or procedures. This information will help us work with your student to minimize unnecessary restrictions, feelings of being treated differently, and possibly absenteeism.

Please send a current picture of your student in order for the student to be easily identified. This information will be distributed to appropriate school personnel on a need-to-know basis and may include bus drivers, substitute teachers, cafeteria staff, and others who work with your student daily.

To help your student, please let us know of any changes in your student's medical condition or emergency daytime phone numbers.

**The following need to be returned to the School Nurse at your student's school:**

- **Seizure Healthcare Plan**
- **FCPS First Aid for Seizures**
- **Physician & Parent/Guardian Authorization for Diastat Medication Administration**

We are looking forward to a great year with your student!

Please call the School Health Services program at 288-2314 if you have any questions.

School Year: _____

# SEIZURE HEALTHCARE PLAN

***(This form will be made available to teachers and appropriate school staff.)***

**Student's Name: _____ DOB:___ / ___ / _____**

**Allergies:** _____

School: _____ Teacher: _____ Grade: _____

Bus Rider: ☐ Yes ☐ No Bus #: AM _____ PM _____ Non-Transported ☐

Parent/Guardian(s) Name(s): _____

Address/Zip Code: _____

Place Student's Picture Here

Call Parent/Guardian 1: – Home: _____ Work: _____ Cell: _____

Call Parent/Guardian 2: – Home: _____ Work: _____ Cell: _____

ALTERNATE PERSON IN CASE OF EMERGENCY:

NAME: _____ RELATIONSHIP: _____ PHONE: _____

PHYSICIAN'S NAME: _____ PHONE: _____

HOSPITAL OF CHOICE: _____

## SEIZURE HISTORY

WHAT TYPE(S) OF SEIZURE(S) DOES YOUR STUDENT HAVE? _____

_____

- DESCRIBE EACH TYPE OF SEIZURE: _____

  _____
- HOW OFTEN DO THEY OCCUR? _____

  _____
- DATE OF LAST SEIZURE: _____
- HOW LONG DO THEY LAST? _____

ANY WARNING SIGNS OR BEHAVIOR CHANGES PRIOR TO SEIZURE(S)? _____

_____

USUAL BEHAVIOR AFTER SEIZURE: _____

ANY SPECIAL ADAPTIVE OR SAFETY EQUIPMENT (I.E., HELMET) NEEDED? _____

_____

**FOR SCHOOL NURSE ONLY:**

STUDENT HAS DIASTAT ORDERED AND AVAILABLE AT SCHOOL? ☐ YES ☐ NO

LOCATION OF DIASTAT AT SCHOOL : _____

*REVIEWED BY:* _____ *RN* *DATE:* _____

School Year: _____

# FCPS FIRST AID FOR SEIZURES

**Parent/Guardian(s), below you will find the Fayette County Public School First Aid procedure for Seizures.**
**Please read it carefully and make any individual changes that apply to your student in the space provided.**

## SEIZURE - CONVULSIONS

1. The Rescue Squad may not need to be called for a person known to have seizure disorder unless the seizure is almost immediately followed by another major seizure, or if the seizure lasts longer than five minutes. Follow the physician's order. **If a major (grand mal) seizure occurs in a person not previously known to have a seizure disorder, the Rescue Squad (911) should be called.**
2. Do not try to restrain student. You can do nothing to stop a seizure once it has begun. It must run its course.
3. Clear the area and protect the head so that no injuries occur from hard or sharp objects. Try not to interfere with movement in any way.
4. Do not force anything between the teeth.
5. Turn student onto his/her side so the saliva will flow out of the mouth.
6. Remain calm. Other students will assume the same emotional reaction as the person administering help. The seizure is painless.
7. When the seizure is over, allow rest.
8. If **DIASTAT** ordered, administer per Physician Order and maintain student's privacy.
9. Parents should be informed of the seizure.
10. Turn the incident into a learning experience for the entire class.

**Individual Changes:** _____

_____

## SEIZURE MEDICATION TAKEN AT HOME

**STUDENT NAME:** _____ **DOB:** _____ **SCHOOL:** _____

**ALLERGIES:** _____

**Medication:** _____ **Medication:** _____

**Dosage / Time:** _____ **Dosage / Time:** _____

**Possible side effects:** _____ **Possible side effects:** _____

* **Any medications to be given at school must be authorized by Parent/Guardian and Physician on official forms according to Fayette County Board of Education Policy. Forms may be obtained from school office staff. Medication should be administered at home if at all possible.**

**Other information or instructions:** _____

_____

**Signature of person completing form:** _____

**Relationship:** _____ **Date:** _____ / _____ / _____

**********

**Reviewed by:** _____, RN **Date:** _____ / _____ / _____

**School:** _____ **School Year:** _____

# PHYSICIAN AND PARENT/GUARDIAN AUTHORIZATION FOR DIASTAT MEDICATION ADMINISTRATION

*The Board of Education of Fayette County has adopted a procedure wherein a member of the staff of the school the student is attending will administer either an injection or prescribed drug in the event of a crisis. The undersigned understands that the staff member administering the above care is not a trained health professional, but is trained by the School Nurse per state law and that this individual will undertake to do his or her best to comply with the recommended procedure as developed by the student's Physician in the case of a life-threatening emergency wherein immediate intervention is required by school personnel.*

*The undersigned Parent/Guardian does hereby consent to the intervention of school personnel in accordance with the instructions contained in the attached form from the student's Physician. Additionally, the undersigned agrees to hold school personnel harmless for any injuries resulting from the emergency care unless the injury was caused by school personnel's negligence.*

## PHYSICIAN ORDER FOR EMERGENCY ACTION PLAN

*To be completed by the student's Physician and returned to School Health: Confidential FAX (859) 288-2313 or by mail: Lexington-Fayette County Health Department, School Health Division, 650 Newtown Pike, Lexington, KY 40508*

**STUDENT'S NAME:** _____ **DOB:** _____

**ALLERGIES:** _____

**DIAGNOSIS:** _____

**SIGNS AND SYMPTOMS WHEN MEDICATION IS NEEDED:** _____

_____

**DRUG ORDERED, DOSAGE AND ROUTE OF ADMINISTRATION:**

_____
Medication/Dose/Route

- **Per protocol, Rescue Squad (911) will be contacted if Diastat is used, unless Physician's order states otherwise.**
- **Notify Parent/Guardian or Emergency Contact.**

**Comments:** _____

_____

X _____ _____
(Physician's Signature) Date

_____ _____
(Physician's Name - Printed) Telephone Number

**** PLEASE NOTE: The School Nurse is NOT always in the school building and trains non-medical staff to administer medication. See above and below.***

## PARENT/GUARDIAN STATEMENT

☐ I, the undersigned Parent/Guardian of the student named above, **request that a *trained staff member administer the above medication** to the student per Physician instructions. I agree to furnish the necessary prescribed medication and agree to notify the School Nurse immediately of any changes. I understand the Fayette County Board of Education Medication Policies & Procedures (09.2241) are readily available for me to read. I sign this voluntarily and with full knowledge of its significance. I agree to pick up any unused medication within two weeks of the last day of school, or it shall be destroyed.

****Parent/Student are responsible to have medication available at school.***

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

**Home Phone:** _____ **Work:** _____ **Cell:** _____

*REVIEWED BY:* _____ *RN Date:* _____