School Year: ______________

Lexington-Fayette County Health Department

SCHOOL HEALTH DIVISION
650 Newtown Pike
Lexington, Kentucky 40508-1197
(859) 288-2314
(859) 288-2313 Fax

VAGAL NERVE STIMULATOR PARENT PACKET

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:

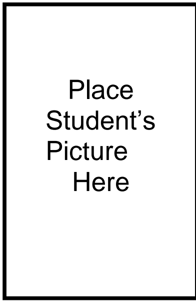
- **Seizure Healthcare Plan (two pages)**
- **Physician & Parent/Guardian Authorization for Emergency Medication Administration**

We are looking forward to a great year with your student! Please call the Health Department's School Health Services Program at 288-2314 if you have any questions.

SEIZURE HEALTH CARE PLAN

School Year__________

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



Student's Name:____DOB:___/____/ ___

School:_____________________________Teacher:___________________Grade: _____

Bus Rider: ☐Yes ☐No Bus #: AM______PM______ Non-Transported ☐

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

Address/Zip Code: ____

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? ______________________

____

STUDENT HAS DIASTAT/OTHER SEIZURE MEDICATION ORDERED AND AVAILABLE AT SCHOOL?

☐ YES ☐ NO

- FOR SCHOOL NURSE ONLY: LOCATION OF SEIZURE MED AT SCHOOL : ________________________

Parent/Guardian(s), below you will find the Fayette County Public School First Aid 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 usually does 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. **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/VALTOCO/NAYZILAM OR VAGUS NERVE STIMULATION** 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:

ROUTINE MEDICATION INFORMATION

Name of Medication:________________________ Name of Medication:________________________

Amount/Time Given: ________________________ Amount/Time Given:________________________

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 the school secretary. Medication should be administered at home if at all possible.**

Other information or instructions: ____

____

Parent/Guardian Signature:____**Date:**____/____/ ____

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*Reviewed by:*_______________________________________, *RN* *Date:*____/____/ ____