HARRISON COUNTY SCHOOLS

OFFICE OF HEALTH SERVICES
445 W. Main Street
Clarksburg, WV 26301
(304) 326-7690
FAX (304) 326-7691

Dear Parent, Date_____

Please complete the enclosed forms and return them to your school nurse. This will serve as a guide for school personnel in direct contact with your child while in the school setting. If your child has emergency medication such as rescue inhaler, epipen or rescue seizure medication, these medications and forms must be delivered to school on or before the first day of school. It is very important everything is complete. Failure to comply with above requirements may result in your child not being able to begin the school year.

If you have any additional questions or concerns feel free to contact me at 304-326-_____. You may also refer to Harrison County Policy Guide or the county website www.harcoboe.com.

Sincerely,

Certified School Nurse

***If your child no longer requires a Health Care Plan for the following health condition, please sign below and return to school nurse.**

My child _____does not require medication or a care plan for (medical condition) _____. If there is any change in my student's medical condition or they will need to have medication at school, I will notify the school nurse immediately.

Parent Signature_____Date_____

***Please note if your student had an emergency medication (Epi Pen, Diastat, etc.) last school year that they no longer require, the school nurse will need an order from the medical provider stating the medication is no longer needed during the school day.**

EPILEPSY FOUNDATION®
Not another moment lost to seizures

Questionnaire for Parent of a Student with Seizures

Please complete all questions. This information is essential for the school nurse and school staff in determining your child's special needs and providing a positive and supportive learning environment. If you have any questions about how to complete this form, please contact your child's school nurse.

Contact Information

Student's Name	School Year	Date of Birth	
School	Grade	Classroom	
Parent/Guardian	Phone	Work	Cell
Parent/Guardian Email			
Other Emergency Contact	Phone	Work	Cell
Child's Neurologist	Phone	Location	
Child's Primary Care Doctor	Phone	Location	
Significant Medical History or Conditions			

Seizure Information

1. When was your child diagnosed with seizures or epilepsy? _____
2. Seizure type(s)

Seizure Type	Length	Frequency	Description

3. What might trigger a seizure in your child? _____
4. Are there any warnings and/or behavior changes before the seizure occurs? ❒ YES ❒ NO
   If YES, please explain: _____
5. When was your child's last seizure? _____
6. Has there been any recent change in your child's seizure patterns? ❒ YES ❒ NO
   If YES, please explain: _____
7. How does your child react after a seizure is over? _____
8. How do other illnesses affect your child's seizure control? _____

Basic First Aid: Care & Comfort

9. What basic first aid procedures should be taken when your child has a seizure in school?

10. Will your child need to leave the classroom after a seizure? ❒ YES ❒ NO
    If YES, what process would you recommend for returning your child to classroom:

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 in log

For tonic-clonic seizure:

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

Seizure Emergencies

11. Please describe what constitutes an emergency for your child? (Answer may require consultation with treating physician and school nurse.)

12. Has child ever been hospitalized for continuous seizures? ❒ YES ❒ NO
    If YES, please explain:

A seizure is generally considered an emergency when:

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

Seizure Medication and Treatment Information

13. What medication(s) does your child take?

Medication	Date Started	Dosage	Frequency and Time of Day Taken	Possible Side Effects

14. What emergency/rescue medications are prescribed for your child?

Medication	Dosage	Administration Instructions (timing* & method**)	What to Do After Administration

** After 2nd or 3rd seizure, for cluster of seizure, etc.* *** Orally, under tongue, rectally, etc.*

15. What medication(s) will your child need to take during school hours? _____
16. Should any of these medications be administered in a special way? ❒ YES ❒ NO
    If YES, please explain: _____
17. Should any particular reaction be watched for? ❒ YES ❒ NO
    If YES, please explain: _____
18. What should be done when your child misses a dose? _____
19. Should the school have backup medication available to give your child for missed dose? ❒ YES ❒ NO
20. Do you wish to be called before backup medication is given for a missed dose? ❒ YES ❒ NO
21. Does your child have a Vagus Nerve Stimulator? ❒ YES ❒ NO
    If YES, please describe instructions for appropriate magnet use:

Special Considerations & Precautions

22. Check all that apply and describe any consideration or precautions that should be taken:

❒ General health _____ ❒ Physical education (gym/sports) _____
❒ Physical functioning _____ ❒ Recess _____
❒ Learning _____ ❒ Field trips _____
❒ Behavior _____ ❒ Bus transportation _____
❒ Mood/coping _____ ❒ Other _____

General Communication Issues

23. What is the best way for us to communicate with you about your child's seizure(s)? _____

24. Can this information be shared with classroom teacher(s) and other appropriate school personnel? ❒ YES ❒ NO

Dates _____
Updated _____

Parent/Guardian Signature _____ **Date** _____

DPC776

Return To School Nurse

HARRISON COUNTY SCHOOL HEALTH SERVICES

EMERGENCY ACTION PLAN

SEIZURE

Student Name: _____ DOB: _____ Grade/Teacher: _____

EMERGENCY CONTACT INFORMATION

Parents/Guardians:	Phone #1:	Phone #2:	Phone #3:
Alternate Contact:	Phone #1	Phone #2:	Phone #3:

Seizure Information

Seizure Type: _____ Normal Length/Frequency: _____

Seizure Triggers or Warning Signs: _____

Daily medication for seizures: _____

Does student have a Vagal Nerve Stimulator (VNS)? □ YES □ NO

Does student have an Emergency/Rescue Medication?□ YES □ NO Name?_____

*Emergency medication to be given for seizures lasting longer than _____ Minutes

*Emergency medication is stored? _____

IF YOU SEE THIS:	DO THIS:
Petit Mal and Psychomotor Seizure **Petit Mal (Absence Seizures) - Staring Spells. May drop an object s(he) is holding or may stumble momentarily. Usually last 2-5 minutes.** **Psychomotor- Some degree of impairment of consciousness may or may not be accompanied by automatic movements like lip smacking, roaming, and non-goal oriented activity. May last several seconds or minutes.**	***Notify the parent. No first aid is needed if no injury.** ***Record and report to nurse and parent.**
Grand Mal/Tonic-Clonic Seizure **Muscles tense, body rigid, followed by a temporary loss of consciousness and violent shaking of entire body.** ***Usually last 2-5 minutes** ***Emergency Medication? Yes / No** ***To be administered for seizures lasting longer than _____ minutes.***	***Keep Calm, note the time when the seizure began** ***Call Code Blue and remove other students from area.** ***Do not restrain the student** ***Clear area around student so that student doesn't injure self.** ***Do not put anything in the mouth.** ***Loosen the student's clothing and remove eyeglasses or any sharp objects or nearby furniture.** ***If vomiting or choking, turn body to the side** ***If loss of bowel/bladder control, please cover student with blanket or jacket for privacy.** ***Do NOT give anything by mouth including medication until seizure is over and fully awake.** ***When seizure is over, have student to rest in a comfortable position.** ***Notify parents of seizure.** ***Record observations of seizure activity.**

Please Sign on Back

IF YOU SEE THIS:	DO THIS:
Danger Signs: ***Seizure lasts longer than 5 Minutes** ***No history of previous seizure.** ***Another seizure starts immediately after the first seizure.** ***Consciousness does not return at the end of a seizure.** ***Bluish color to lips AFTER seizure ends.** ***Stops breathing** ***If student is a diabetic, pregnant, or has a head injury or high fever.**	***Call 911** ***Begin CPR and Rescue Breathing if breathing stops** ***Call Parents**

Symptoms to Expect After a Seizure ***can last a few minutes or hours***

(Tiredness, weakness, sleepy, difficult to arouse, somewhat confused, regular breathing)

*These are all **NORMAL** post seizure*

I understand and agree that information in this Emergency Action Plan will be shared with appropriate school staff.

_____ _____

Parent/Guardian Signature Date

School Nurse Received and Reviewed: _____ _____

School Nurse Signature Date

To Be Completed By School Nurse

Location of medicine_____ ***Authorized person to give medicine_____***

School_____

Harrison County Schools Medication Form

Student Information

Student Name _____
Last First Middle

Birth Date _____ Homeroom Teacher _____ Grade _____

Medication Allergies_____

Physician

This section of the Medication Form is to be filled out by a licensed prescriber. Medication orders are valid for the current school year including any summer school programs or extended school year programs. A medication order is required for any prescription and non-prescription (over the counter) medication. If there is any change in medication, dosage, time, or route, a new medication order must be received before the medication can be administered by school personnel. By signing this form, the licensed prescriber is authorizing that this medication may be given at school.

(Use one form for each medication)

Medication _____ Diagnosis _____

Dose _____ Time _____ Route _____

Intended Effect of Medication _____

Potential Side Effects for this Medication _____

Other Medication(s) taken by student _____

If rectal Diastat/Diazepam or Klonopin is prescribed, may this be administered by unlicensed trained personnel? ___Yes ___No

Please note that Nasal Versed cannot be delegated to unlicensed personnel

May the student self-administer their emergency medication per county policy? ___Yes ___No

May the student carry their emergency medications on them per county policy? ___Yes ___No

Name and Title of Licensed Prescriber (**PRINT**) _____

Address _____

Phone _____ Fax_____

Signature of License Prescriber _____ Date _____

Parent/Guardian

Parent/Guardian Authorization

I understand the following:

- *Medication must be brought by an adult to the school in the original container and properly labeled with the child's name.
- *The licensed prescriber may be contacted concerning the medication order for reasons including, but not limited to clarification, effectiveness, administration time, dosage, discontinuation, or new medication order.
- *Medication administration and procedures may be delegated to school personnel who have been trained by and remain under direct or indirect supervision of the school nurse.
- *A photograph of my child may be taken to assist in the correct administration of my child's medication.
- *Information may be shared with appropriate school personnel to insure the safety of my student.
- *it is the parent/guardian responsibility to replenish long-term and emergency medications as needed and retrieve unused or expired medication from the school.
- *At no time will non-emergency medication be sent home with the student. It will be the responsibility of a parent/guardian to pick up all remaining medications from the school.

I hereby give permission for my child to receive medication at school per the Harrison County Schools Medication Policy and as ordered by my child's licensed prescriber. I have read and understand that Harrison County Board of Education and its employees are exempt from any liability, except for willful and wanton conduct.

Parent/Guardian Signature_____ Date_____

Form Received and Reviewed by School Nurse _____ Date _____
Signature