Parent ☐
Physician ☐

Bullitt County Public Schools

1040 Highway 44 East
Shepherdsville, Kentucky 40165

502-869-8000
Fax 502-543-3608
www.bullittschools.org

SEIZURE PARENT PACKET

Dear Parent and/or Guardian;

I am sending home forms that will be used by school personnel in caring for your child's medical needs during the 2018-2019 school year. Attached is a seizure school action plan and medication permission form that will need to be completed **in full** with physician signature prior to bringing the medication to school.

The following conditions must be met before bringing medication:

- **Physician/Parent Authorization Form is complete and on file at school;**
- **Medication Permission Form is complete for each medication and on file at school;**
- **New medical forms must be updated each school year.**

As our policy 09.2241 states, " All prescription medication, original or refill, shall be brought to school in the most current pharmacy labeled container which includes the student's name, date, medication, dosage, strength, and directions for use including frequency, duration, and mode of administration, prescriber's name, pharmacy name, address and phone number. Labels that have been altered in any way shall not be accepted."

Please remember that the schools are not to administer any medication without proper paperwork and signatures on file. We appreciate your understanding and cooperation with this policy.

Sincerely,

Lesa A. Howell, RN

Lesa A. Howell, R.N. B.S.N.
District Health Coordinator
Bullitt County Public Schools

School Year _____________
Grade _________________

Equal Education and Employment Institution

BULLITT COUNTY PUBLIC SCHOOLS

SEIZURE ACTION PLAN

Student's Name Date of Birth

Parent/Guardian Phone Cell

Other Emergency Contact Phone Cell

Seizure Information

Seizure Type	Length	Frequency	Description

Known Triggers:
 Flashing Lights, Computers, Electronic Games Hormonal, Emotional Stress or Anxiety Lack of Sleep Other ____________________

Warning Signs or Auras before a Seizure:
Headache Vision Changes-blurred vision, double vision, spots, blinking lights
Body Temperature (Hot or Cold) Other: ______________________________________
Student's reponse after a seizure ____

Seizure Emergency Protocol (check all that apply & clarify below)
Contact first aid responders
Time event
Monitor breathing
Notify parent or emergency contact
Administer emergency medication for seizure activity long than: 3 minutes 5 minutes
to be kept in: office with student (may require 504)
Call 911 if emergency medication given or any condition listed in emergency box
Notify health coordinator
Other

Basic Seizure First Aid

* Stay calm & track time
*Do not restrain
*Remove hazards
*Keep child safe
*Do not put anything in mouth
*Stay with child & monitor until fully conscious

For tonic-clonic (grand-mal) seizure:
*Ease to the floor
*Keep airway open/watch breathing
*Loosen tight clothing at neck
*Protect head
*Turn child on side

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

Treatment Protocol during School Hours (include daily and emergency medications) **(must complete medication form 09.2241 AP. 21)**

Emerg. Med. √	Medication	Dosage & Time of Day Given	Common Side Effects & Special Instructions

Does student have a **Vagus Nerve Stimulator**? Yes No If YES, describe magnet use:

Special Considerations and Precautions (regarding school activities, sports, trips, etc.)

Describe any special considerations or precautions: ____

✕**Physician Signature** ____ **Date** ________________________ **Phone** _________________

I am the parent/guardian of the above named student and give consent and permission for the information on this form to be shared with teachers, principals, and other school personnel that have direct contact with my child for the current school year. I understand that a trained staff member may administer prescribed medication and/or assist my child to comply with his/her physician's prescribed medications or treatments if needed. I understand that I have the ultimate responsibility for providing the school with an adequate supply of medication to enable the physician's orders to be followed. Parent/Guardian also agrees that the replacement of expired medication is their responsibility. I hereby give permission for the above information to be verified with the above health care provider.
I am fully aware and have been informed by the above primary care provider that my child's condition is of such a serious nature that, if it occurs, there would not be sufficient time to remove him/her from the school premises or to await the arrival of medical help. I hereby give my authorization and consent to trained non-medical school personnel to give prompt treatment, as specified above, to my child. I hereby agree to release and hold BCPS free and harmless for any claims, demands, or suits for damages from any injury/complication that may result from such treatment or medication described by me or prescribed by my child's physician.

✕**Parent/Guardian Signature** _____________________________________ **Date** _______________________**Phone**________________________

Permission Forms for Medication

PHYSICIAN AUTHORIZATION FOR MEDICATION FORM

Student's Name: _________________________ Grade: ________ Age:_______ Date of Birth: _____/_____/_____

School: ____

COMPLETED BY THE PARENT/GUARDIAN AND HEALTH CARE PROVIDER

Procedure 09.2241 AP.1 – Medication shall be in the original container, dated upon receipt. Prescribed medication/self-administration/over-the-counter medication needed for longer than three (3) days requires a parent/guardian and Health Care Provider to complete the required form.

Name of medication:_____________________________________ **Reason for medication:**__________________________________ **Instructions: Time:**_______________ **Dose:**____________________ **Start Date:**_______/_______/______ **Stop Date:**_____/_____/_____	**Name of medication:**_____________________________________ **Reason for medication:**__________________________________ **Instructions: Time:**_______________ **Dose:**____________________ **Start Date:**_______/________/______**Stop Date:**_____/_____/_____
Signs & symptoms of emergency administration: ____ Restriction and/or important side effects: ☐ No restrictions ☐ Yes. Please describe:___________________________ ☐ Other *Student must carry this medication on his/her person and self-administer during school hours: ☐ *Yes **(If yes, please initial below)** ☐ No **SPECIFIC TO FIELD TRIPS:** ☐ Trained personnel to assist student to self-medicate (School personnel will hold medication until dosing time) ☐ *Student to self-administer **(*MD to initial below)** (Student will hold medication on their person) ☐ Student requires medication to be administered (School personnel will hold medication and administer)	Signs & symptoms of emergency administration: ____ Restriction and/or important side effects: ☐ No restrictions ☐ Yes. Please describe:___________________________ ☐ Other *Student must carry this medication on his/her person and self- administer during school hours: *Yes **(If yes, please initial below)** ☐ No **SPECIFIC TO FIELD TRIPS:** ☐ Trained personnel to assist student to self-medicate (School personnel will hold medication until dosing time) ☐ *Student to self-administer **(*MD to initial below)** (Student will hold medication on their person) ☐ Student requires medication to be administered (School personnel will hold medication and administer)

______***(MD INITIALS)** The above named student has been instructed on the care, storage, dosage, and use of the above medication(s) and has sufficient knowledge and ability to self-administer the medication(s) in the school setting and while on field trips.

____
*Physician/Health Care Provider Signature/Date

Physician Practice name:____

Address:____

Phone: (___)_______________________ Fax: (___)_________________

PARENT AUTHORIZATION FOR ABOVE LISTED MEDICATIONS.

I give permission for ____ to receive the above medication(s) at school according to
Student's Name
standard school policy and expressly hold harmless, and waive any liability on behalf of, the school or its employees and agents concerning any injuries or reactions resulting from administration or lack of administration of the above medication. For on-going medications, I understand that I have the ultimate responsibility for providing the school with an adequate supply of medication to enable orders from a physician or health care provider to be followed.

Date: __________________________ *Signature:* ____ *Relationship:* _______________________

Home Phone: ___________________ *Work Phone* ____________________________ *Emergency Phone* ________________________________

I/we reviewed the statement and authorization for completion.

Administrator/designee ____ Date ____

Consent Form for Mutual Exchange of Information

Student's Name: ____ Date: ____________________

Date of Birth: ____________________ Parent/Guardian: ____

Address: ____

I the parent/guardian of the above named student hereby authorize the mutual exchange of information including use and/or disclosure of protected health information and educational records between the Bullitt County Public School's District Health Coordinator and the physician, individual or organization listed below.

Name: ____ Phone #: ___________________
(Physician's name)

Address: ____

The information will be used or disclosed upon request for the following purposes:

- ☐ Developing a medical plan for the student at school
- ☐ Assessing the need for a medical transfer
- ☐ Assessing the need for the student to access the Home Hospital Program
- ☐ Addressing medical needs related to treatment for the following condition or injury ____ on or about ____
- ☐ Reviewing medical records covering the period of time ___________________ to _______________
- ☐ Addressing issues related to the student missing school/excessive absences
- ☐ Other: ____

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to the named physician/practice/organization and the Bullitt County Public Schools. I also understand that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by federal laws and regulations regarding the privacy of my protected health information.

This authorization expires on the following date or event: ________________________________

I certify that I have received a copy of this authorization. I further certify that I am the parent or legal guardian of the above-named student or that I am the student of majority age and have the authority to sign this release.

____ ______________________________

Signature Date

Public Law 93-380 (Federal Family Educational Rights and Privacy Act of 1974) specifically states that school records may be released to third parties provided:

1. Written consent is obtained from the parent, guardian, or student of legal age.
2. The reason for the release is stated.
3. The identity of the third party is specified.
4. The parents receive a copy of the record, if desired.
5. The records to be released are specified.