Individualized Seizure Action and Nursing Care Plan for the 2015-2016 School Year

This student is being treated for a seizure disorder. The information provided below is intended to assist school personnel should a seizure occur during school hours.

The Following is to be Completed by the Parent

Student's Name_____ DOB_____ Age_____

Allergies_____ Significant Medical History_____

Date of last seizure_____ How long does a typical seizure last?_____

How often do seizures occur?_____

School_____ Grade_____ HR Teacher_____

Parent/Guardian_____ Phone_____ _____

Parent/Guardian_____ Phone_____ _____

The Following is to be Completed by the Medical Provider

Date of seizure diagnosis _____

Medical Diagnosis_____

Current medication(s)_____

_____

Special considerations or safety precautions_____

Student Specific Seizure Emergency Plan Per Medical Provider

Call 911 and parent/guardian for seizure activity in this student for the following:

☐ Absence (petit mal) seizure lasting longer than_____ minutes

☐ Generalized Tonic Clonic (grand mal) seizure lasting longer than_____ minutes

☐ Cluster seizure activity _____ or more seizures in_____ hour

☐ Other seizure (indicate type)_____ lasting longer than _____ minutes

☐ Administer Diastat (write order here)_____

Basic Seizure First Aid

- Stay calm & note time seizure began
- Keep student safe
- Do not put anything in student's mouth
- Do not restrain
- Protect head
- Stay with student & watch breathing

Other considerations for student with seizure emergency at school:

√ Complete Seizure Observation Form
(Send with EMS if possible)

√ Notify School Nurse (RN)

Treating Physician_____ Phone_____ Fax_____

Physician Signature_____ Date_____

Parent Signature_____ Date_____

School Nurse Signature_____ Date_____

LEON COUNTY SCHOOLS
AUTHORIZATION FOR MEDICATION OR TREATMENT

(Use one form for each medication. This permission form is valid for the current school year only.)

I hereby certify that it is necessary for my child, _____(first/last name)/_____ (date of birth), to be given the medication or treatment listed below during the school day, including when s/he is away from school property on official school business. I hereby authorize the School Board of Leon County, Florida (LCSB), and Florida Department of Health in Leon County (DOHLC) and their officers, employees, contractors and agents to assist my child with medication administration and/or to supervise my child's self-administration of medication(s) as directed by his/her prescribing physician(s). I acknowledge and agree that non-health professionals, trained in medication administration, may assist my child with medication administration.

This form must be signed for all the following: medicines given by mouth, inhaled, by nebulizer, on skin, patch, injection, etc. **Only FDA-approved prescribed and over-the-counter medicines will be accepted.**

Name of medication: _____

Reason for medication (diagnosis): _____

Dosage to be given: _____Route (mouth, injection, etc.): _____

Time(s) of administration: _____Allergies: _____

Beginning date:_____Ending Date: _____Amount of liquid or count of pills:_____

Emergency telephone numbers:

Parent/Guardian:_____H: _____C: _____

Parent/Guardian:_____H:_____C: _____

Doctor's Name:_____Doctor's Phone Number:_____

Prescription and over-the-counter medications/treatments shall come in original, labeled containers. Changes in medication times or dosage can only be made by written prescription from the physician, which may be faxed/scanned to school health personnel. Over-the-counter drugs/treatments shall **only** be administered up to **five calendar days** without a signed a licensed prescriber statement. A licensed prescriber must provide signed authorization for a student to self-carry or self-administer medications/treatments allowed by statute 1002.20 and LCSB policy **(see back of form).**

Parents are responsible for safe delivery of medication to the school (students may not transport medication unless authorized to self-carry emergency medications) and for picking up any leftover medication within ONE WEEK after the ending date. Medication left after this time will be discarded according to LCSB policy.

I hereby consent for the Leon County School District to disclose protected health information, as needed, to provide health services to my child. I understand this health information may be shared with the health care provider listed above, and I hereby authorize the exchange of this information. I also give permission for the information on this form to be utilized by the staff of this school and any school health personnel providing school health services in the district for the limited purpose of meeting my child's health and educational needs.

I hereby release, indemnify, and hold harmless LCSB, DOHLC and any of their officers, employees, contractors and agents any and all lawsuits, claims, demands, expenses, and actions against them associated with their activities assisting my child with medication administration and/or supervising my child's self-administration of medication(s), provided they follow the physician's orders on record. I also hereby agree to indemnify and hold LCSB, DOHLC and their officers, employees, contractors and agents harmless from any and all lawsuits, claims, demands, expenses, and actions against them arising from harm to any person caused by my child's actions with regards to a self-carried medication.

Date_____ Parent/Guardian Signature_____

Florida Department of Health in Leon County

CONSENT FOR SHARING OF PROTECTED HEALTH INFORMATION

School Year_____

Student's Name: _____
DOB: _____
School: _____

I hereby consent to health information being shared to carry out treatment or clarify medical orders in order to keep my child safe while at school. I understand that Registered Nurses from the Florida Department of Health inLeon County, School Health Division, may be giving and receiving information pertaining to the management of my child's medical condition with the following organizations:

(Please check *and* initial <u>all</u> that apply)

___ [**X**] Leon County School District
___ [ ] Tallahassee Memorial Hospital Diabetes Center
___ [ ] Children's Medical Services
(Name of case manager: _____)
___ [**X**] Florida Department of Health in Leon County (Health Department)
___ [ ] Tallahassee Pediatric Foundation

___ [ ] Primary Physician_____
(Please fill in Physician name)
___ [ ] Specialist Physician_____
(Please fill in Physician name)

I may request a notice of the complete description of such uses and disclosures prior to signing this consent.

I understand that I have the right to revoke this consent in writing.

_____ _____
Signature Date

Specialized Health Care Procedure:

Administration of Diastat

Definition/Purpose: Epilepsy is a neurological condition that makes people susceptible to seizures. A seizure is a change in sensation, awareness, or behavior brought about by a brief electrical disturbance in the brain. **Diastat** (DI-a-STAT) is a formulation of diazepam specifically designed for rectal administration to control prolonged seizures and bouts of increased seizure activity (clusters).

Requirements: Parents/guardians are required to sign a written authorization for the Administration of Diastat. Parents/guardians are also required to complete a Medication School Permission Form. A physician's (written and signed) order must also be obtained (Physician's Order for Diastat).

Personnel Authorized to Perform Procedure: Can be performed by an RN or LPN, or by any designated staff member trained by the nurse. Training will be reviewed on a yearly basis.

Equipment Needed: Gloves, Diastat kit from locked cabinet, blanket (for privacy), and pillow to place under student's head (if possible)

Classroom Duties:

Seizure Activity Begins:

1. Call out time Seizure Activity begins.
2. ID person responsible for completion of Seizure Monitoring Form.
3. ID person responsible for caring for student with seizure activity.
4. ID person responsible for other students' care.
5. ID person responsible for initiating emergency measures if seizure lasting longer than time indicated on Physician's Order for Diastat.

If generalized tonic clonic (Grand Mal), Absence (Petit Mal) seizure or other seizure (indicated by physician) lasts longer than time indicated on Physician's Order for Diastat:

1. Dial 911 identify school, student name, age, and condition and that **Diastat** is being administered **rectally**.
2. Administer Diastat rectally.
3. Monitor respirations, may need to provide rescue breathing.
4. Call Office to notify of EMS activation.

Administering Diastat

Gather supplies. Check medication for:

- Right student
- Right medication
- Right route (rectal)
- Right dose (See Physician's Order)
- Right time (See Physician's Order)

Procedure:

1. Put person on their side where he or she cannot fall.
2. Get medicine (Diastat kit). (Do not leave student unattended.)
3. Put on gloves.
4. Get syringe from kit. Push up with thumb and pull to remove protective cover from syringe.
5. Lubricate rectal tip with lubricating jelly.
6. Turn person on side facing you.
7. Bend upper leg forward to expose rectum.
8. Separate buttocks to expose rectum.
9. Gently insert syringe tip into rectum.
10. Slowly count to 3 while gently pushing plunger in until it stops.
11. Slowly count to 3 before removing syringe from rectum.
12. Slowly count to 3 while holding buttocks together to prevent leakage.
13. Keep person on side facing you, note time given, and continue to observe.

Office duties:

1. Have an employee wait outside for ambulance and provide directions to student's location (may be identified by office staff).
2. Notify parent/guardian

When EMS arrives:

1. Turn over care to EMS.
2. Provide all Emergency Medical information to EMS personnel
3. (COPIES, NOT ORIGINALS):
    - Emergency and Medical information Card
    - Physician's order for Diastat
    - Parent/Physician Authorization Form for Specialized Health Care Procedure (for Diastat)
    - Seizure Monitoring Form, if possible
4. Give used Diastat syringe and package with prescription label to EMS personnel (or dispose of properly).
5. Complete Accident Report.

Parent and Physician: Please complete attached page.

Parent Authorization for
Specialized Health Care Procedure

I, the undersigned, who is the parent/guardian of:
_____

request that the following health care service:

Administration of Diastat

I understand that a trained designated staff member will be performing this procedure. It is my understanding that in performing this procedure, the designated person(s) will be using a standardized procedure which has been approved by our physician. I will notify the school immediately if the health status of our child changes, I change physicians, or there is a change or cancellation of the procedure.

Signature of parent/guardian _____
Date _____

Physician's Order for
Specialized Health Care Procedure

Student's Name _____ DOB _____

Procedure: **Administration of Diastat**

Check one:
_____ I have reviewed the Health Care Procedure and approve of it as written.

_____ I have reviewed the Health Care Procedure and approve of it with the attached amendments

_____ I do not approve of the Health Care Procedure. A substitute procedure is attached.

Duration of the procedure (not to exceed current school year): _____

Physician's Signature: _____ Date: _____

ACCEPTING MEDICATION FROM PARENTS –FAQ's

- Prescribed medications required to be given during school hours will be accepted.
- Over-the-Counter (OTC) medications will be accepted and administered for temporary medical conditions for a period no longer than 5 calendar days, and cannot be renewed beyond 5 days without a healthcare provider's written authorization.
- All medications must be transported to and from school by a parent, legal guardian, or designated adult.
- Before assisting any student with medication, a Medication Permission Form must be completed and signed by a parent or legal guardian.
- A separate Medication Permission Form must be completed for each medication, and is valid for the current school year in which it is completed (prescription medications only).
- All medications must be in the original container or packaging, and must contain labeled dosing instructions.
- Medication and doses of medication must be age-appropriate. Some non-prescription medications are not recommended for children. Check the box/bottle for this information.
- Before leaving medications at school, all medications must be counted, verified and documented by the parent / guardian and staff member on the Medication Log.
- Medications containing aspirin (Excedrin, Goody Powder, etc.) will not be accepted without a physician's written order, due to the association with Reye Syndrome.
- Only FDA-approved medications will be accepted. No vitamins, nutritional supplements, etc.
- Parents / Guardians may not change the dose or time of administration of any prescription medication. A physician's written order or new prescription bottle reflecting the change is required.
- Completed Medication Permission Forms must match the prescription or OTC dosing instructions.
- Students who carry medications allowed by Florida Statutes must have a completed Medication Permission Form and a written order from the physician to carry the medication on file in the school clinic.