Health Services Department
937-542-3346

Health Forms for Students with Seizures (Epilepsy)

Please complete packet and return to your child's school nurse.

What is in this packet?

1) **STUDENT SEIZURE HISTORY** – for parent to describe student's seizure history and list current medications.

2) **MEDICATION AUTHORIZATION FORM / GENERAL MEDICATION FORM**
- **Guidelines for Medications at School** – on page 2 of Medication Authorization Form
- Most oral seizure medications can be given at home before or after school, but if an oral seizure medication must be given at school, please complete this form
- Must be signed by parent and Health Care Provider (HCP)
- Signed form and medication should be brought to school by a responsible adult

3) **SEIZURE EMERGENCY ACTION PLAN**
- Your Health Care Provider's Seizure Action Plan form works or you may use the **school's Seizure Emergency Action Plan** included in this packet.
    - Please include any current emergency seizure medications needed for school, i.e. nasal Versed (midazolam) or rectal Diastat (diazepam).
    - Please complete the Medication Authorization Form / General Medication Form (above) if an oral seizure medication cannot be given at home before or after school.

4) **VAGAL NERVE STIMULATOR (VNS) / DIASTAT® / VERSED MEDICATION/TREATMENT AUTHORIZATION FORM** - Please have this form completed and signed by your Health Care Provider if applicable; and return form to the school nurse each school year.

5) **AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION**

Questions? - Please call your school nurse

DAYTON PUBLIC SCHOOLS

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STUDENT SEIZURE HISTORY

Parent, please complete information below so your school nurse can provide care and create an Emergency Action Plan for your child, if needed. Please return this form to your school nurse.

CONTACT INFORMATION:

Student's Name: _____Date of Birth: _____School Year:_____
School: _____Grade: _____Homeroom: _____
Parent/Guardian Name: _____Email: _____
Parent Guardian Tel: (H) _____(W) _____(C) _____
Neurologist:_____Tel: _____
Primary Care Doctor: _____ Tel: _____
Significant medical history or conditions: _____

SEIZURE INFORMATION:

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

Seizure Type(s)	***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? ❑No ❑Yes
   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? ❑No ❑Yes
   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?_____
9. Describe what constitutes an emergency for your child? (Answer may require consultation with treating physician and school nurse).
10. Has child ever been hospitalized for continuous seizures? ❑No ❑Yes
    If YES, please explain: _____

SEIZURE MEDICATION AND TREATMENT INFORMATION

11. What medication(s) does your child take? (*Please include prescription emergency rescue medication- ie. Diastat, Versed*)

Medication	**Date Started**	**Dosage**	**Frequency and time of day taken**

12. What medication(s) will your child need to take during school hours?_____
13. Should any of these medications be administered in a special way? ❑No ❑Yes
    If YES, please explain:_____
14. Should any particular reaction be watched for? ❑No ❑Yes
    If YES, please explain:_____
15. Any special considerations & safety precautions for school activities: ❑General health❑Gym/ sports (physical activity) ❑ Physical functioning ❑ Learning ❑Field trips ❑ Recess ❑ Bus transportation ❑Mood / coping ❑ Behavior ❑ Other Explain: _____
16. Does your child have a Vagal Nerve Stimulator (VNS)? ❑No ❑Yes
    If YES, please describe instructions for appropriate magnet use or include physician's orders:_____

_____

I authorize Dayton Public Schools to communicate and share health information with appropriate school personnel to create an emergency action plan if necessary and to aid in present and future educational decisions.

Parent Signature: _____Date: _____Date Updated: _____
Reviewed by School Nurse: _____ Date: _____

DAYTON PUBLIC SCHOOLS

Medication Authorization Form
General Medication Form
(Includes Asthma Inhaler and Epinephrine Auto-Injector Use)

Student Information

Student name			Date of birth
Student address			
School	Grade/Class	Teacher	Schoolyear
School Nurse		Phone:	Fax:

Prescriber Authorization

Name of medication	Diagnosis	
Dosage	Route	Time/Interval
Date to begin medication	Date to end medication	
Special instructions		
Treatment in the event of an adverse reaction		
Epinephrine Autoinjector (self-carry) ❑ Not applicable ❑ Yes, as the prescriber I have determined that this student is capable of possessing and using this autoinjector appropriately and have provided the student with training in the proper use of the autoinjector.		
Asthma Inhaler (self-carry) ❑ Not applicable ❑ Yes, if conditions are satisfied per ORC 3317.716, the student may possess and use the inhaler at school or at any activity event or program sponsored by or in which the student's school is a participant.		
Procedures for school employees if the student is unable to administer the medication or if it does not produce the expected relief:		
Possible Severe Adverse Reaction(s) per ORC 3317.716 and 3313.718 a) To the student for whom it is prescribed (that should be reported to the prescriber) b) To a student for whom it is not prescribed who receives a dose		
List any known drug allergies and reaction.		

Prescriber signature	Date	Phone	Fax
Prescriber name (print) Reminder note for prescriber: ORC 3313.718 requires backup epinephrine autoinjector and best practice recommends backup asthma inhaler.			

Parent/Guardian Authorization

☑ I authorize an employee of the school board to administer the above medication. ☑ I understand that additional parent/prescriber signed statements will be necessary if the dosage of medication is changed. ☑ I also authorize the school nurse for the _____ school year to confer with the licensed prescriber regarding my child's health and treatment issues as they pertain to the medication/diagnosis and his/her attendance, educational, and behavioral management.

☑ Medication form must be received by the principal, his/her designee, and/or the school nurse. ☑ I understand that the medication must be in the original container and be properly labeled with the student's name, prescriber's name, date of prescription, name of medication, dosage, strength, time interval, route of administration and the date of drug expiration when appropriate.

Parent/Guardian signature	Date	#1 contact phone	#2 contact phone

Parent/Guardian Self-Carry Authorization

▭ *For Epinephrine Auto-injector: As the parent/guardian of this student, I authorize my child to possess and use an epinephrine auto-injector, as prescribed, at the school and any activity, event, or program sponsored by or in which the student's school is a participant. I understand that a school employee will immediately request assistance from an emergency medical service provider if this medication is administered. I will provide a backup dose of the medication to the school principal or nurse as required by law.*

▭ *For Asthma Inhaler: As the parent/guardian of this student, I authorize my child to possess and use an asthma inhaler as prescribed, at the school and any activity, event, or program sponsored by or in which the student's school is a participant.*

Parent/Guardian signature	Date	#1 contact phone	#2 contact phone

Received by (school nurse): _____ Date: _____

Adapted from Ohio Department of Health: Revised May 2016, Reviewed Feb 2020
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Guidelines for Medications at School

- DPS has one Medication Authorization form for all medications—oral, injectable, emergency (ex. Epinephrine Auto-Injector, asthma inhalers), and student self-carry medications.
- Any student needing to take medication during school hours **must have a Medication Authorization form** completed and signed by the parent and physician/prescribing healthcare provider.
- **All medication must be in the container in which it was dispensed** by the pharmacist or healthcare provider.
- The medication and Medication Authorization form must be brought together to the school by a parent or responsible adult.
- School personnel may not give over-the-counter medications unless prescribed by a healthcare provider. A Medication Authorization form must be completed and signed.
- No new medication can be given until the school nurse has reviewed it and checked it in.
- Routine injectable medication can only be given by a school nurse, parent (or parent- designated adult), or self-administered by the student.
- Changes in medication must be provided by the healthcare provider.
- Routine daily medication ordered three times a day or less may not need to be taken at school. The medication should be given before school, after school and at bedtime unless it is time-specific for during the school day. **It is best for morning medication to be given at home.**
- All medication orders must be renewed each school year.
- Parents are notified in writing to pick up all remaining medications at the end of the school year. Per DPS policy, any unused medications not claimed by the last day of school each year will be destroyed.
- Parents will be required to pick up all medications with the exception of inhalers and Epinephrine Auto-Injectors that the student already has written permission from their primary healthcare provider to carry on him/herself.

Original: 2015; Revised: 2015, 2018, 2020

EPILEPSY FOUNDATION

DAYTON PUBLIC SCHOOLS Health Services

Seizure Action Plan

Effective Date

This student is being treated for a seizure disorder. The information below should assist you if a seizure occurs during school hours.

Student's Name | Date of Birth

Parent/Guardian | Phone | Cell

Other Emergency Contact | Phone | Cell

Treating Physician | Phone

Significant Medical History

Seizure Information

Seizure Type	Length	Frequency	Description

Seizure triggers or warning signs:

Student's response after a seizure:

Basic First Aid: Care & Comfort

Please describe basic first aid procedures:

Does student need to leave the classroom after a seizure? ❒ Yes ❒ No

If YES, describe process for returning student 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

Emergency Response

A "seizure emergency" for this student is defined as:

Seizure Emergency Protocol
(Check all that apply and clarify below)

- ❒ Contact school nurse at _____
- ❒ Call 911 for transport to _____
- ❒ Notify parent or emergency contact
- ❒ Administer emergency medications as indicated below
- ❒ Notify doctor
- ❒ Other _____

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)

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** _____

Parent/Guardian Signature _____ **Date** _____

DPC772

Adapted for use for DPS, April 2020

Health Services Department
937-542-3346

Vagal Nerve Stimulator (VNS) / Diastat® / Versed Medication/Treatment Authorization Form

Contact Information
Student's Name: _____Date of Birth: _____School Year:_____
School: _____Grade: _____Homeroom: _____
Parent/Guardian Name: _____Email: _____
Parent Guardian Tel: (H) _____(W) _____(C) _____
Neurologist: _____ Tel: _____
Primary Care Doctor: _____Tel: _____
Significant medical history or conditions: _____

Diagnosis (include type of seizure): _____

Medication/Treatment Order(s):
❑ **Vagal Nerve Stimulator (VNS):**
- ✓ Swipe VNS magnet at onset of seizure
- ✓ If seizure continues, swipe VNS every ____ seconds up to ____ times
- ✓ Additional orders: _____

❑ **Diastat®) (diazepam) Rectal Gel**
- ✓ Diastat® rectal gel _____ mg
- ✓ For seizure lasting more than _____ minutes. Give only ____ dose(s) in 24 hours.
- ✓ Additional orders: _____

❑ **Versed (midazolam) Nasal Spray**
- ✓ Versed (Midazolam) nasal spray _____ mg
- ✓ For seizure lasting more than _____ minutes. Give only ____ dose(s) in 24 hours.
- ✓ Additional orders: _____

☒ **Call 911 if:**
- ✓ Seizure does not stop by itself or with VNS swipe(s) within _____ minutes
- ✓ Child does not wake up within _____ minutes after a seizure has ended
- ✓ Anytime Diastat® or Versed is given (per Dayton Public School policy)

Administration to begin _____Administration to end _____
List all other medication this child is taking: _____
Severe adverse reaction to be reported to the physician: _____
Please list any medication allergies: _____
Special instructions: _____
Name of Physician: _____
Address: _____Phone: _____
Physician's Signature: _____ Date: _____

Part II: TO BE COMPLETED BY PARENT OR GUARDIAN AND RETURNED TO SCHOOL
I request that the above medication be administered to my child according to the instructions provided. I agree to deliver the medicine to the school in the container in which it was dispensed by the prescribing physician or licensed pharmacist. I grant permission for the school nurse to confer with the above licensed prescriber regarding my child's health and treatment issues as they pertain to the above medication/diagnosis and his/her educational and behavioral management needs. If the above information changes, I will submit a revised statement signed by the physician.

****Signature of Parent/Guardian**: _____ Date: _____
Address: _____
Home Phone: _____Work Phone:_____ Cell Phone: _____

TO BE COMPLETED BY SCHOOL STAFF:
(Only the School Nurse or designated trained school staff will administer VNS/Diastat/Versed)
Person(s) Designated/Authorized for VNS/Diastat/Versed are: _____

Health Services Department
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Authorization for Release of Student Medical Information

Dayton Public Schools

Patient Information	Last name	First name	Middle		
	Address		City	State	Zip
	Birthdate	Other possible names	Phone #		
	School Attending:		Grade:	Home Room:	
Information Requested	☐ Immunization record ☐ General / Medical ☐ Counseling Record ☐ Emergency / Urgent care record ☐ Other:		☐ Neurological ☐ Surgical ☐ Orthopedic ☐ Otorhinolaryngology (ENT) ☐ Ophthamology		
Action	☐ Mail Copies ☐ Fax copies				
	This information may be disclosed to and used by Dayton Public Schools. Mail to: School		The following individual or organization is authorized to make the disclosure:		
	School Representative	Title			
	Address		Address		
	City / State / Zip		City / State / Zip		
	Phone#	Fax#	Phone#	Fax#	
Reason Needed	☐ Continuity of Medical Care ☐ At request of the Individual ☐ School Related		☐ Legal Reasons ☐ Special Education ☐ Other:		
Authorization	I hearby authorize Dayton Public Schools (DPS) to release and/or receive medical information, to/from the above party. This authorization may include release of information concerning treatment of drug or alcohol abuse, drug related conditions, Human Immunodeficiency Virus (HIV) test results, diagnosis or AIDS related conditions, alcoholism, and/or psychiatric/psychological conditions.				
	I understand that this authorization shall remain in effect for the school year 20____ - 20____, unless an earlier expiration date is specified in this space (_____). I also understand that I may withdraw this authorization at anytime by written notification to the above parties involved. However, this written notification cannot effect actions that have taken place based on my prior authorization.				
	I understand that if the person or entity that receives the above information is not a healthcare provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.				
	Signature of Parent or Guardian		Date		
	Relationship to Student				
	Signature of School Representative		Date		

Health Services 2/2004; Rev March 2020