Wynne Public Schools

P.O. Box 69
Wynne, Arkansas 72396

Seizure Care In The School

Date_____

Student_____ Grade_____

Dear Parent/Guardian,

Our records indicate that your child has a seizure disorder. Good management of your child's condition is important for success at school. If your child requires emergency medication, please complete the attached packet. Return the clearly labeled medication(s) and any needed supplies in person to the school nurse. If your child does not require the use of emergency medication for seizures, please sign and return this form.

Content of packet to be completed and returned to school nurse if emergency medication is needed.

1. Medication Administration Consent Form- Parent signs
2. Consent to Communicate with child's doctor- Parent signs
3. Seizure Action Plan-**Doctor** completes, Parent signs

____MY child ONLY has a history of Seizures and no longer takes medications.

____My child still takes daily seizure medication at home, but does not require emergency medications.

Parent/Guardian:_____ Date:_____

If you have any questions, please call me at the number below. Your doctor may fax completed, signed forms to the school.

Thank you,

School Nurse

District	Primary	Intermediate	Jr. High	Sr. High
Jessie Bouland, RN	Erin Oguin, RN	Christine Flahrity, RN	Rebecca Strasser, RN	Lindsay Marotti, RN
(870) 238- 5030	238-5050 ext 0353	238-5060 ext. 0329	238-5040 ext. 0272	238-5070 ext. 0229
	Fax (870)238-5053	Fax (870)238-5063	Fax (870)238-5043	Fax (870)238-5009

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(870) 238- 5030	238-5050 ext 0353	238-5060 ext. 0329	238-5040 ext. 0272	238-5070 ext. 0229
	Fax (870)238-5053	Fax (870)238-5063	Fax (870)238-5043	Fax (870)238-5009

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Medication Administration Consent Form

Student Name_____DOB_____Grade_____HmRm_____

Name of Medication_____ Dosage_____

Time to be Taken_____ Ordering Physician_____

Reason for Medication_____

Other instructions_____ Epi Pen Expiration date: _____
IF APPLICABLE

Medication Procedures:

1. Only medications that are ordered and labeled to be taken with meals, at a specified time during school hours, **or 4 or more times** a day will be administered at school. Morning doses should be taken at home with a snack prior to coming to school.

2. Parent/guardian/designated adult must bring/sign in/count all medications, prescription and/or over-the-counter (OTC), to the nurse's office. Students are NOT permitted to have medication in their possession on the school bus or school campuses. **EXCEPTION: EMERGENCY** medications if consents/Doctor orders are on file in nurse's office; these must be renewed annually.

3. All medications must be in the original container with the student's prescription label in place. OTC medications should have the student's name written on it and have the manufacturer's dose and directions included.

I certify that at least one dose of this medication has previously been given (exception: emergency medication) with NO adverse reactions. Therefore, I give permission for the school to administer the above medication to my child according to the Board of Education procedure (see above). I will not hold the school staff responsible for any undesired reaction or effects which may occur from the medication. Only emergency medications will be sent on off-campus activities. I give permission for the school nurse to contact the prescribing doctor about medication(s) and to take a photograph of my child for identity purposes.

For an oral controlled substance, in the unavailability of a school nurse, ***the parent may delegate*** to the following designee: Dawn Hess (nurse's aide), _____, _____, to administer the medication at school or school event.

Signature of Parent/Guardian_____ Date_____

Contact Number_____

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Wynne, Arkansas 72396

Consent To Share Information

Student's Name_____

Student's Date of Birth_____

Student's School ID#_____

I authorize personnel of the Wynne School District and personnel with any relevant agency or provider to access and exchange information in my or my child's files that may be beneficial in providing any or all needed services. I understand that I am giving my permission to share confidential information in an effort to better serve the needs of my family.

_____

Print Name of Parent/Legal Guardian Date

_____

Signature of Parent/Legal Guardian Date

_____

Nurse Signature Date

WYNNE SCHOOL DISTRICT

SEIZURE EMERGENCY ACTION PLAN

STUDENT: _____DOB: _____ GRADE: _____

DIAGNOSIS: _____

EMERGENCY CONTACTS:

	NAME	RELATIONSHIP	CELL #	WORK #	HOME #
1.	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____

PHYSICIAN: _____ PHONE: _____

Type of seizures: _____

Frequency: _____Date of last seizure: _____

Appearance of student's typical seizure and duration: _____

Possible triggers to avoid: _____

Does student need any special activity adaption/protective equipment at school NO_____

YES ____If yes, explain: _____

Is student allowed to participate in physical education or other physical activities: NO ____

YES ___ If no, explain limits: _____

Are emergency medications needed to treat seizures at school? NO_____ YES _____

If yes, is student allowed to ride the bus without rectal diastat? NO_____ YES_____

	Medications	Dosage	Route	When
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____

Possible side effects: _____

Side effects that need to be reported to Parent/Doctor: _____

Call 911: At onset of seizure NO ____ YES _____. Call 911 if seizure lasts: _____

Can student remain at school when recovered from post seizure symptoms: YES ___ NO ____

Special instructions/comments: _____

_____ _____

PHYSICIANS SIGNATURE DATE