

SEIZURE

Seizure Action Plan

Name: _____ Birth Date: _____

Address: _____ Phone: _____

1st Emergency Contact /Relation: _____ Phone: _____

2nd Emergency Contact / Relation: _____ Phone: _____

Seizure Information

Date of Last Known Seizure: _____

Seizure Type/Nickname	What Happens	How Long It Lasts	How Often

Triggers

Daily Seizure Medicine

Medicine Name	Total Daily Amount	Amount of Tab/Liquid	How Taken (time of each dose and how much)

Other Seizure Treatments

Device Type: _____ Model: _____ Serial# _____ Date Implanted _____

Dietary Therapy: _____ Date Begun _____

Special Instructions: _____

Other Therapy: _____

Seizure First Aid

- ☐ Keep calm, provide reassurance, remove bystanders
- ☐ Keep airway clear, turn on side if possible, nothing in mouth
- ☐ Keep safe, remove objects, do not restrain
- ☐ Time, observe, record what happens
- ☐ Stay with person until recovered from seizure
- ☐ Other care needed: _____

Call 911 if...

- ☐ Generalized seizure longer than 5 minutes
- ☐ Two or more seizures without recovering between seizures
- ☐ "As needed" treatments don't work
- ☐ Injury occurs or is suspected, or seizure occurs in water
- ☐ Breathing, heart rate or behavior doesn't return to normal
- ☐ Unexplained fever or pain, hours or few days after a seizure
- ☐ Other care needed: _____

When Seizures Require Additional Help

Type of Emergency (long, clusters or repeated events)	Description	What to Do

"As Needed" Treatments (VNS magnet, medicines)

Name	Amount to Give	When to Give	How to Give

Health Care Contact

Epilepsy Doctor: _____ Phone: _____

Primary Care: _____ Phone: _____

Other Health Care Provider: _____ Phone: _____

Special Instructions: _____

I have read this action plan and agree with the information. I also give permission for the school nurse to discuss the management of epilepsy with members of the medical team.

My signature _____ Date _____

Provider signature _____ Date _____

***This form does not replace the Louisiana Medication and/or Procedure Order Form.**

***This form constitutes a plan of care for the student in the school setting.**

**AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION
TO BE COMPLETED BY PARENT/LEGAL GUARDIAN**

PART 1: CONTACT INFORMATION		COORDINATOR: _____	
Student's/Child's Legal Name	Date of Birth	Social Security #	Case #
 Parent/Legal Guardian _____ Telephone # _____ Mailing Address _____ City/State/Zip Code _____			
PART 2: RECORD REQUEST			
Complete Box A OR B below. Both boxes may not be completed on the same form.			
A. Specify the records to be released for the treatment date(s) listed below in Part 3: <div style="display: flex; justify-content: space-between;"><div><input type="checkbox"/> Medical records <input type="checkbox"/> Individual Education Plan (IEP) <input type="checkbox"/> Academic Achievement Assessment <input type="checkbox"/> Eligibility report <input type="checkbox"/> Cumulative Record <input type="checkbox"/> Related Services Report <input type="checkbox"/> Speech Evaluation <input type="checkbox"/> Prescription of Therapy and Medical Services from Physician <input type="checkbox"/> Medication Name(s) and Prescribed Dosage(s)</div><div><input type="checkbox"/> Test Results <input type="checkbox"/> Phone Consult <input type="checkbox"/> Other _____ _____ _____</div></div>		B. If initialed below, I specifically authorize release of the following: <div style="text-align: center; padding-top: 20px;">Psychotherapy notes and records indicating psychological or psychiatric impairment(s) _____ Initials of parent/legal guardian</div>	
PART 3: AUTHORIZATION			
This does not authorize the release of the following: drug and alcohol use counseling and treatment and HIV/AIDS and sexually transmitted disease and treatment.			
I AUTHORIZE: Name: <u>St. Landry Parish School Board</u> (School System) <div style="display: flex; justify-content: space-around;"><input type="checkbox"/> TO OBTAIN information FROM</div> AND/OR <div style="display: flex; justify-content: space-around;"><input type="checkbox"/> TO RELEASE information TO</div> Name: _____ (Hospital, physician, Service Agency, health provider) Address: _____ For treatment date(s): _____			
The information is to be released for the purpose(s) of: <div style="display: flex; justify-content: space-between;"><div><input type="checkbox"/> Evaluation to determine eligibility or continued eligibility for special education services <input type="checkbox"/> Providing occupational therapy treatment <input type="checkbox"/> Providing physical therapy treatment</div><div><input type="checkbox"/> Designing an individual educational program <input type="checkbox"/> Determining appropriate placement for treatment needs <input type="checkbox"/> _____</div></div>			
<p>I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the same medical records department receiving this authorization form. I understand that the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____. If I fail to specify an expiration date, event or condition, this authorization will expire nine (9) months from the date of authorization. An authorization is voluntary. I will not be required to sign an authorization as a condition of receiving treatment services or payment, enrollment, or eligibility for health care services. Information used or disclosed by this authorization may be re-disclosed by the recipient and will no longer be protected under the Health Insurance Portability & Accountability Act of 1996.</p>			
<div style="display: flex; justify-content: space-between; margin-top: 20px;"><div>_____ Signature of Student or Legal Representative (Parent/Legal Guardian must sign if student < 18)</div><div>_____ Date</div><div>_____ (Relationship to student)</div></div>			
<div style="display: flex; justify-content: space-between; margin-top: 20px;"><div>_____ Signature of Witness</div><div>_____ Date</div></div>			

STUDENTS WITH SPECIAL HEALTH CARE NEEDS

TRANSPORTATION PLAN

Student's Name _____

School _____ Teacher's Name _____

School Bus # _____ a.m. _____ p.m. Bus Driver Name _____

Parent/Guardian Name _____

Address _____

Telephone (home) _____

Work Phone (Dad) _____ Work Phone (Mom) _____

Babysitter's Name _____ Phone _____

Babysitter's Address _____

Disability / Diagnosis: _____

Medications: _____ Side Effects: _____

1. Mode of transportation on bus: (check one)
_____ wheelchair _____ car seat _____ seat belt _____ chest harness _____ regular seat
2. Walks up bus stairs independently: _____ yes _____ no
3. List student's method of communication: _____
4. List any behavioral difficulties student displays: _____
5. List equipment that must be transported on bus (such as oxygen, life sustaining equipment, wheelchair equipment, climate control, etc.): _____
6. Wheelchair restraint checklist: (check all that apply)
_____ seat belt _____ chest harness on _____ wheelchair brakes on
_____ tray off _____ headrest and hip abductor in place _____ other _____

School Signature

Date

ST. LANDRY PARISH SCHOOL BOARD

EMERGENCY PLAN

Name of Student _____ Teacher _____ Grade _____

Name of Parent / Guardian _____

Phone Numbers: Home _____ Work _____ Cell _____

Alternate Adult Contact Person: (1) _____ Phone# _____

Alternate Adult Contact Person: (2) _____ Phone# _____

Relationship of alternate persons to student: (1) _____ (2) _____

Physician's Name _____ Phone Number _____

Poison Control Number: 1-800-256-9822

Student's allergy history: _____
(List all medications, food, plants, insects, etc. that your child is allergic to)

Field Trip Designated Person: Trained Personnel _____

Parent/Guardian _____

Alternate Adult Person _____

I am aware that if my child has an emergency in school and I am not available, the school principal or alternate will have my child transported to the emergency room, and I will be responsible for payment of emergency care.

IF AN EMERGENCY OCCURS, SCHOOL PERSONNEL WILL DO THE FOLLOWING:

- 1. If the emergency is life threatening, immediately call 9 – 1 – 1.**
- 2. Stay with the student, or designate another adult to do so.**
- 3. Contact the parent/guardian, or alternate adult (named above).**
- 4. Follow school protocol.**
- 5. Contact school nurse at your child's school.**

Signature of Parent/Guardian

Date Signed

**ST. LANDRY PARISH SCHOOL BOARD
PUPIL APPRAISAL CENTER
127 BLAIR STREET
OPELOUSAS, LA 70570**

Activity Restrictions

Date: _____

Student's Name: _____

Medical Condition: _____

Can the student participate in Physical Education Classes?
____ Yes ____ No

Are there any activity restrictions for this student?
____ Yes ____ No

What are the student's limitations/restrictions? Please list them:

Physician's Name (Print)

Physician's Signature

Physician Address

Telephone Number

Fax Number

Thank you for your time and assistance in completing this documentation.

St. Landry Parish School Nurses