Pierce City Schools

Parent/Guardian Seizure Letter

Dear Parents or Guardians of : _____

Grade: _____

School Year: _____

You are receiving this letter because you indicated on the student health information form that your child has seizures.

In order for us to provide the best care for your child, we need your help with the following.

Please initial ONE of the following:

_____ My child NO longer has seizures and receives NO treatment or medication.
Initials

_____ My child has seizures, but they are not active and receives NO treatment or medication.
Initials

Date of last seizure: _____

_____ My child has seizures, but they are not active. They DO receive preventative treatment or medication.
Initials

Date of last seizure: _____

_____ My child has seizures and receives treatment and medication at:
Initials

_____ Home _____ School

Parent Signature: _____ Date: _____

IF YOU MARKED ONE OF THE LAST TWO CHOICES, we ask that you complete the applicable attached forms and return them to the school nurse as soon as possible. We require these forms every year, as the authorization is only good for one school year.

- **Parent Information Form** —This gives us important health information regarding your child's seizures.
- **Seizure Orders/ Action Plan** —This form explains what medications and actions the doctor prescribes if your child has a seizure. Your help in ensuring this is completed by your child's physician is appreciated.
- **Parent Authorization of Medication at School** —This form gives the health team and school permission to give your child seizure medications that need to be given at school.

Should you have any questions or concerns, please feel free to call

(417) 476-2515 ext. 2100 (Elementary) or ext. 3100 (Middle & High School)

Thank you,

Sarah Elbert, RN

Kristi Barchak, RN

Piece City R-VI

School Nurses

Pierce City Schools

SEIZURE CARE INFORMATION FROM PARENT/GUARDIAN

Your school nurse will use the following information to plan for safe care of the student should a seizure occur at school. Parents/Guardians are notified and EMS (911) called if a student has difficulty breathing, the seizure lasts longer than 5 minutes, if more than one seizure occurs, or if a long period of time has occurred since the last seizure.

Student name _____ D.O.B. _____

Grade_____

School Year _____

Parents/Guardians _____Phone _____

Emergency Contact _____ Phone _____

Physician for the seizure disorder _____ Phone_____

Last date your child was seen by this doctor _____ Next appt. _____ Age diagnosed _____

List the type(s) of seizure(s) your child has (grand mal, petit mal, partial, focal, ect.).

_____

_____

_____

What triggers the seizure(s)? Describe how your child behaves when a seizure starts.

_____

_____

_____

How long do the seizure(s) last? _____

How often does your child have a seizure? _____

Medications or procedures given at HOME: _____

SCHOOL: _____

Diastat? ____Y _____N Vagal Nerve Stimulator (VNS)? _____Y _____N

How does your child get to and from school? ____ Walk/ ride bike ____ School Bus ____ Car

Parent/Guardian signature _____ Date _____

Pierce City Schools

SEIZURE ORDERS

Student Name: _____DOB: _____ Grade_____ School Year _____

Physician: _____ Phone: _____ Fax: _____

Seizure Information			
Seizure Type	Length	Frequency	Description
Seizure Triggers or Warning Signs			Student's Response after Seizure

When was the last known seizure? _____

Age of DX _____ Last MD visit _____ Co-existing diagnosis _____

Medications at home _____

Treatment Protocol During School Hours (Include Daily and Emergency Medications)		
Medication	**Dose & Time**	**Special Instructions**

If Diastat Ordered

- If Diastat ordered, has the child received this dose before? Y _____ N _____
  - Note: If student has NOT received this dose before, EMS will be called after Diastat administered.
- Call EMS every time Diastat administered? Y ____ N ____
- **EMS will be called if:**
  - One dose of Diastat does not stop the seizure in _____ minutes
  - Another seizure begins within _____ minutes after one ends
  - Parent is unable to pick-up student within 30 minutes after Diastat administration.
  - If a seizure occurs on the bus or a field trip
  - Other instructions: _____

Does Student have a Vagus Nerve Stimulator? Y _____ N _____

Can magnet be swiped more than once? Y _____ N _____ Time interval _____

Special considerations and Precautions (for school activities, sports or PE, trips, transportation) :

_____

Physician's Signature: _____ Date: _____

Pierce City Schools

Date: _____

Parent/Guardian Authorization of Medication at School

(complete one form for each medication)

Student Name: _____DOB: _____ Grade _____

<u>Only those medications that are medically necessary during school hours or written in an IEP should be sent to school.</u>

Medication administration during school hours requires the following:

- Parent/Guardian written authorization for medication administration at school
- Medication in the original, properly labeled container (name of medication with strength, dosage and directions; name of prescribing physician and date)
- Medication label has the student's first and last name
- The first dose of this medication for the current condition/illness **<u>may not be given at school.</u>**

Please complete the following:

Med Name and Strength (only 1 med per page)	Dosage	Time(s) to be given at school	How it's taken (mouth, eye, skin, ect)	Reason/Medical condition for med administration

Medication Start Date: _____ Medication Stop Date: _____

Note: the first dose of any medication may NOT be given at school

Has the student received this medication before? Yes _____ No _____

If Yes, Date and Time of last dose given _____

1. I request that the above medication be given during school hours as ordered by the physician. I also request that the medication be given on field trips, as prescribed.
2. I release school personnel from liability in the event adverse reactions result from taking the medication.
3. I will notify the school of any change in the medication (dosage, time, ect).
4. I give permission for the school nurse to communicate, as needed, with the student's teachers about the student's health condition(s) and the action(s) of the medication.
5. I give permission for the medication to be given by trained personnel as delegated by the Principal.

Please Note: Elementary school students may not carry medication home (except inhalers) and should not transport controlled substances to school, including ADD/ADHD medication; all medication must be transferred from adult to adult.

I understand I am responsible for retrieving the mediation from the School Health Office when it is no longer needed or when the school year ends.

_____ _____

Parent/Guardian Printed Name Phone Number

_____ _____ _____

Parent/Guardian Signature Date Relationship to Student

Reviewed by RN: _____ Date: _____