

Office of the CCSD School Nurse

Dear Parent /guardian,

You have indicated that your child: _____
has **ASTHMA, ALLERGIES OR A SEIZURE DISORDER**. Mississippi State law requires that we have:

- **ACTION PLAN SIGNED BY YOU AND CHILD'S DOCTOR (whether the child is on medication or not)**
- **CCSD MEDICATION AUTHORIZATION FORM AND PROCEDURE FORM SIGNED BY YOU AND CHILD'S DOCTOR**
- **PERMISSION TO SELF ADMINISTER CHECKED ON PLAN(S) THAT IS SIGNED BY DOCTOR (IF YOUR CHILD IS TO CARRY INHALER OR EPI- PEN)**

IF YOUR CHILD IS NOT CURRENTLY UNDER A DOCTOR'S CARE IN ANY WAY OR RECEIVING ANY TREATMENT OR MEDICINE PLEASE CHECK THE BOX BELOW WHERE INDICATED AND SIGN AND DATE THE FORM AS INDICATED.

_____ My child is not currently under the care of a physician for asthma and is currently not taking any medication for asthma. I acknowledge being informed of the new asthma law. If my child's health status changes and a diagnosis of **ASTHMA, ALLERGIES OR SEIZURES** is given or medication is started, I understand that I am to provide the school with the above information.

Date: _____

Parent /Guardian _____

Thank you again -

CCSD School Nurse

Please fax back to your child's school

AES- (662) 285-4099

WES- (662) 547-7074

CCHS- (662) 285-4149

FCE- (662) 547-7119



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

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

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 _____

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 _____

Self-Administer Medication Permission Form
(Auto-injectable epinephrine and/or rapid-acting bronchial inhalers ONLY)

Student: _____ Date: _____

This letter confirms that the above-named student is a current patient and is being treated for (i.e., health condition): _____

I agree that the student is responsible and capable of self-administration of the following medications at school (please check those that apply):

_____ **Rapid-acting bronchial inhaler (please include name, dose, and frequency of the medication):** _____

_____ **Auto-injectable epinephrine (please include name, dose, and frequency of the medication):** _____

***The medications must remain in their original container(s) with the prescribing information intact.*

Healthcare Provider Signature: _____

I, the parent/guardian of _____ agree that my child is responsible and capable of self-administration of the above medication(s). I accept full responsibility and liability for my child carrying and self-administering this medication(s).

Parent/Guardian Signature: _____ Date: _____

I, _____ (student) agree that I am being given permission by my healthcare provider, my parent(s)/guardian, and my school to carry and take my own above-named medication(s) as needed. I will keep the permitted medication in my book bag/locker. I will not share with or give my medication to anyone. I will not take my medication for any reason except as prescribed. I understand that my parent(s) and I accept full responsibility for my carrying and taking my own medication as prescribed above. I understand that I will lose the privilege of carrying the medication if I misuse it or do not adhere to the above rules.

Student Signature: _____ Date: _____

School Nurse Signature: _____ Date: _____

This form must be renewed each school year.

CCSD OFFICE OF THE SCHOOL NURSE

Procedures for Administering Medications to Students

The first dose of any newly prescribed medication should be given at home. **Medications that are to be given only one time a day or medications that can be given before or after school should be given at home.** In the absent of the school nurse, a designated school personnel is authorized to give prescribed medication. **Since parents are primarily responsible for administering medication to their child, we encourage you to come to school to administer needed medication to your child.** However, Choctaw County School District does recognize there are circumstances when it is necessary to administer medication to a student during school hours. This may enable the student to attend school, improve or maintain their health status and/or improve their potential to learn. For the safety of our students, the following procedures will be followed:

1. If your child has to take medicine at school, **the school must receive a Choctaw County School District Medication Permission Form signed by the parent AND the child's health care provider**, stating the name of the medication, dosage, route, and the time the medication is to be given at school. Permission Forms are required for both prescription and over the counter medication.
2. A new medication permission form must be completed each school year and for each medication and whenever there is a change in the student's authorized healthcare provider, or a change in the medication dosage, method by which the medication is required to be taken, or date or time the medication is to be taken.
3. **DO NOT SEND MEDICATION TO SCHOOL WITH STUDENTS.** All prescribed medication is to be brought to school by the parent or guardian in a container **labeled by the pharmacist.** The information on the container must match the information on the medication permission form. Any change in the prescription requires a new permission form. Pick up all discontinued, outdated or unused medicine before the end of the school year. Medications not picked up will be discarded in an appropriate legal manner.
4. Students with emergency medications, such as inhalers, insulin, or epi-pens, may carry and self-administer these medications only if the healthcare provider and parent sign the permission form and it is on file at school. Parents of these students are advised to contact the school nurse.
5. It is the parent's responsibility to ensure that their child has needed emergency medications on field trips and school sponsored events. If your child requires medication on a field trip, we encourage the parent to accompany the child. If this is not possible, the medication will be administered under the supervision of your child's teacher.

I understand and agree to the above procedures regarding medication administration.

Parent Signature

Date

Student's Name

Teacher's Name

Please fax back to your child's school

AES- (662) 285-4099

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FCE- (662) 547-7119

THIS FORM EXPIRES AT THE END OF THE SCHOOL YEAR

SCHOOL MEDICATION PERMISSION FORM

This form must be completed fully by parent and physician in order for schools to administer prescribed medication. A NEW Medication Permission form must be completed each school year for EACH medication and whenever there is a change in the student's physician, or a change in the medication dosage, method by which the medication is required to be taken, or date(s) or time(s) the medication is required to be taken.

TO BE COMPLETED BY PHYSICIAN

Student's Name: _____ Allergies _____

Diagnosis: _____

Medication Name: _____

Route: _____ Dosage: _____ Time _____

Side Effects: _____

Is it necessary for this medication to be administered at school: YES _____ NO _____?

Other medication student is taking _____

**** Physician Signature****

Date

PARENTS' AUTHORIZATION

I give permission for the school nurse or delegate to administer the above prescribed medication to my child. I give my consent for the Choctaw County School District to contact my child's physician regarding administration and effectiveness of prescribed medication. I agree to release the Starkville School District and its employees who are acting within the scope of their duties from any liability or compensation in any and all claims arising from the administration of medication at school to my child. I understand that I may refuse consent for this permission at any time by notifying the school nurse or principal in writing. I also understand that the nurse may reject requests for administration of medication. I understand and agree to the following responsibilities regarding medication administration:

1. The first dose of any newly prescribed medication should be given at home.
3. Non-prescription medication must be in the original container with the label intact.
4. An adult must bring the medication to the school and pick up any outdated or unused medication.
5. DO NOT SEND MEDICATION TO SCHOOL WITH THE STUDENT *EMERGENCY MEDICATIONS ARE ALLOWED AFTER MEETING REQUIREMENTS

Signature parent/legal guardian

Date

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MEDICAL RECORDS RELEASE

**CHOCTAW COUNTY SCHOOL DISTRICT
OFFICE OF THE SCHOOL NURSE**

I _____ as legal representative of

PARENT/GAURDIAN

_____ do hereby give consent for the release

STUDENT

of the following medical information to Choctaw County School District to the care of the school nurse:

The school district shall keep this information confidential and shall not re-release the information without the written signed consent of the above named parent/guardian.

Date

Signature of Parent/Guardian

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