Harrison County School Health Clinic

EMERGENCY ACTION PLAN

Confidential

Student Name:______________________________

Date of Birth:______________________________

Date of Implementation:______________________

This EAP is appropriate for use for ONE YEAR from the date of implementation.

EMERGENCY ACTION PLAN

Harrison County School Health Clinic
STUDENT INFORMATION

Student Name:______________________________**DOB**________________**YEAR**______

SCHOOL:______________________________GRADE:______TEACHER:__________

Student's address:______________________________PHONE:______________________

Medication Allergies or OTHER Allergies: ____

____

Mother's/ Guardian's Name:____

Phone: (H)__________________**(C)**______________________**(W)**________________

Father's / Guardian's Name: ____

Phone:(H)__________________**(C)**______________________**(W)**________________

Emergency Contact #1: ____

Phone:____

Relationship: ____

Emergency Contact #2:____

Phone: ____

Relationship: ____

Provider's Name: ____

Date last seen: ____

Phone: ____

Provider's Address:____

HEALTH CONDITION: (Diabetes, Asthma, Seizures, Severe Allergy, Other	Medications	Care needed at school. PLAN INITIATED

Other information or instructions: ____

____

Nurse Signature	Person Interviewed	Date: Initial Interview and yearly updates

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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:____________

Treating Physician:______________________________ Phone: ____________

Significant medical history:____

SEIZURE INFORMATION:

Seizure Type	*Length*	*Frequency*	*Description*

Seizure triggers or warning signs:____

Student's reaction to 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 (grand mal) 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
- ☐ Notify doctor
- ☐ Administer emergency medications as indicated below
- ☐ Other______________________

A Seizure is generally considered an Emergency when:
- ✓ A convulsive (tonic-clonic) seizure lasts longer than 5 minutes
- ✓ Student has repeated seizures without regaining consciousness
- ✓ Student has a first time seizure
- ✓ Student is injured or has diabetes
- ✓ Student has breathing difficulties
- ✓ Student has a seizure in water

TREATMENT PROTOCOL DURING SCHOOL HOURS: (include daily and emergency medications)

Daily Medication	Dosage & Time of Day Given	Common Side Effects & Special Instructions

Emergency/Rescue Medication

____

Does student have a **Vagus Nerve Stimulator (VNS)**? YES NO

If YES, Describe magnet use______________________

SPECIAL CONSIDERATIONS & SAFETY PRECAUTIONS:

(regarding school activities, sports, trips, etc.)

Physician Signature:______________________ **Date:**__________

Parent Signature:______________________ **Date:**__________

Harrison County School Health Clinic
Permission Form for Prescribed Medication

TO BE COMPLETED BY SCHOOL PERSONNEL

School: ____________ School Year: ____________ Date form received: ____________

I acknowledge receipt of this Physician's Statement and Parent Authorization: ____________

TO BE COMPLETED BY PHYSICIAN OR AUTHORIZED PROVIDER

Student Name ____________ **Date of Birth** ____________

Name of Medication: ____________

Reason for Medication: ____________

Allergies: ____________

Form of Medication: □ Tablet/Capsule □Liquid □Inhaler □Injection □Nebulizer □Other ____________

Instructions (Schedule and dose to be given at school): ____________

Start Date: □ Date Form Received □ Other ____________

Stop Date: □ End of School Year □ Other date/duration: ____________

□**For episodic/emergency events only**

Restrictions and/or important side effects: □ NO Restrictions

□Yes (please describe) : ____________

Special Storage Requirements: □ None □ Refrigerate □ Other: ____________

Physician Signature ____________ Physician's Name ____________

Date ____________ Phone ____________ Address ____________

*****FOR SELF ADMINISTRATION ONLY*****

Pursuant to KRS 158.832 to KRS 158-836 Harrison County Schools permits a student to possess and self-administer asthma, diabetes or anaphylaxis medication at school and at school-related functions upon completion of the following information by the parent/guardian and the student's physician and waiver of liability by the parent/guardian.

This student has been instructed on self-administration of this medication: **(to be completed for asthmatic, diabetic, or severe allergic reaction (anaphylaxis) ONLY):**

□ NO □ Supervision required □ Supervision NOT required

This student may carry this medication: □ YES □ NO

Please indicate if you have provided additional information:

□ On the back side of this form □ As an attachment

Physician Signature ____________ Date ____________

TO BE COMPLETED BY PARENT/GUARDIAN

I give permission for (name of child) ____________ to receive the above stated medication at school according to the standard school policy. I release the **Harrison County School Board** and its employees from any claims or liability connected with its reliance on the permission.
(Parent/Guardian to bring the medication in its original container.)

Date ____________ Name: ____________ Signature ____________

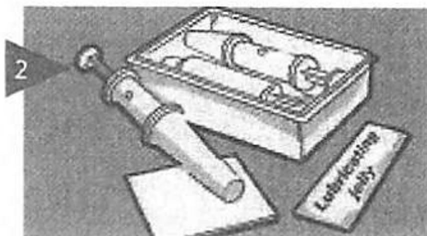
Relationship to Child: ____________

Home Phone: ____________ Work Phone: ____________

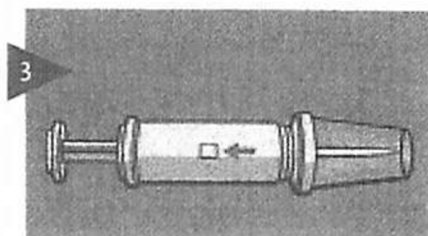
Other Emergency Contact Name: ____________ Phone: ____________

CHILD ADMINISTRATION INSTRUCTIONS

Put person on their side where they can't fall.



Get medicine.



Get syringe. *Note: seal pin is attached to the cap.*

Push up with thumb and pull to remove cap from syringe. **Be sure seal pin is removed with the cap.**

Lubricate rectal tip with lubricating jelly.

Turn person on side facing you.

Bend upper leg forward to expose rectum.

Separate buttocks to expose rectum.

Gently insert syringe tip into rectum.
Note: rim should be snug against rectal opening.

SLOWLY... COUNT OUT LOUD TO THREE...1...2...3

Slowly count to 3 while gently pushing plunger in until it stops.

Slowly count to 3 before removing syringe from rectum.

Slowly count to 3 while holding buttocks together to prevent leakage.

ONCE DIASTAT® IS GIVEN

Keep person on the side facing you, note time given, and continue to observe.

CALL FOR HELP IF ANY OF THE FOLLOWING OCCUR

- Seizure(s) continues 15 minutes after giving DIASTAT® or per the doctor's instructions: ______________________
- Seizure behavior is different from other episodes
- You are alarmed by the frequency or severity of the seizure(s)
- You are alarmed by the color or breathing of the person
- The person is having unusual or serious problems

Local emergency number: ____________ Doctor's number: ____________
(Please be sure to note if your area has 911)

Information for emergency squad: Time DIASTAT® given:_________ Dose: _________

DIASTAT® Indication

DIASTAT® AcuDial™ (diazepam rectal gel) is a gel formulation of diazepam intended for rectal administration in the management of selected, refractory patients with epilepsy, on stable regimens of AEDs, who require intermittent use of diazepam to control bouts of increased seizure activity, for patients 2 years and older.

Important Safety Information

In clinical trials with DIASTAT®, the most frequent adverse event was somnolence (23%). Less frequent adverse events reported were dizziness, headache, pain, vasodilatation, diarrhea, ataxia, euphoria, incoordination, asthma, rash, abdominal pain, nervousness, and rhinitis (1%–5%).

Diastat® (diazepam rectal gel) Diastat® AcuDial™ (diazepam rectal gel)

DISPOSAL INSTRUCTIONS ON REVERSE SIDE

D955-0308