Jefferson County Public Schools Health Services

Primary Care Provider (PCP) Authorization: Seizure Monitoring (Side One)

2012-2013 School Year

Student Name: _____Date of Birth: _____School: _____

TYPE OF SEIZURE:

☐ Tonic-clonic (Grand Mal)
☐ Absence (Petit Mal)
☐ Simple Partial
☐ Complex Partial
☐ Other_____

Does the student have a Vagal Nerve Stimulator?
☐ Yes ☐ No

VNS magnet should be kept with the student at all times

IF child has **VAGAL NERVE STIMULATOR** please specify when to use and how often (i.e. Q minute X 4 then administer diastat):
_____

Does the student have Diastat?
☐ Yes ☐ No

IF child has **DIASTAT**, please specify:
DOSE: _____MG PER RECTUM AND ADMINISTER AT:
☐ Onset of seizure
☐ _____minutes after onset of seizure
☐ Other: _____

Diastat will be kept in a secured area in the office or nurse's office (if applicable), or in the classroom with trained adult.

- Diastat will not be transported on the bus, EXCEPT for field trips ONLY. During the field trip the Diastat should be kept and administered by trained staff ONLY.

Does this child take oral/g-tube/nasal seizure medication?
☐ YES* ☐ NO
***IF YES, PLEASE COMPLETE THE AUTHORIZATION TO GIVE PRESCRIPTION AND/OR OVER THE COUNTER MEDICATIONS FORM**

EMERGENCY PLAN OF ACTION

1. Time the seizure.
2. Ease the student to the floor, remove hazards in the area, and turn student onto his/her side to keep airway open.
3. Use vagal nerve stimulator (VNS) and/or rectal diastat as indicated.
4. Call EMS 9-911: if Diastat is administered, if **any** seizure lasts longer than five minutes; if there is any continued, progressive respiratory distress; if another seizure starts right after the first; if school has no record of student history of seizures, and/or if this PCP form indicates in writing to call at onset of seizure.
5. However, if diastat is administered and a nurse is available in the building to monitor the stable student, the nurse may observe the student until parent/guardian arrives. If unable to reach parent/guardian within 30 minutes of administering diastat and/or parent/guardian are unable to get to the school within one hour of administering diastat, EMS 9-911 will be called.
6. Notify school personnel trained in CPR/first aid to respond and initiate CPR if needed prior to EMS arrival.
7. Notify parent/guardian.
8. If EMS is called the student must be transported via EMS to emergency facility, or parent/guardian must sign release with EMS and then parent/guardian assumes responsibility for student. The student may not return to school that day.
9. When student is transported via EMS, JCPS staff must ride with student unless parent and/or emergency contact accompanies them.
10. Document all seizure activity on the JCPS Health Services Log.
11. If the student requires medical treatment while on the bus, the driver will contact EMS.
12. Other: _____

Initials/Date	
Reviewed by Health Services	_____
Entered by Health Services	_____
School received/sent to Health Services	_____

Please complete both sides of this form.

Jefferson County Public Schools Health Services

Primary Care Provider (PCP) Authorization: Seizure Monitoring (Side Two)

2012-2013 School Year

Student Name: _____Date of Birth: _____School: _____

Please specify likely characteristics.						Other/Comments
Duration	Specify seconds, minutes, etc.					
Aura	Is there an Aura? ☐ Yes ☐ No Conditions or behaviors that usually precede the seizures:					
Extremities	(circle one)	Limp	Flexed	Extended	Jerking	
	Right/Left Arm	☐	☐	☐	☐	
	Right/Left. Leg	☐	☐	☐	☐	
Eyes	Rolled Back			☐ Yes	☐ No	
	Twitching Back and Forth			☐ Yes	☐ No	
	Looking to Right/Left (circle one)			☐ Yes	☐ No	
	Staring			☐ Yes	☐ No	
Mouth	Drawn to Right/Left (circle one)			☐ Yes	☐ No	
	Bites Tongue/Cheek			☐ Yes	☐ No	
	Teeth Clenched			☐ Yes	☐ No	
Breathing	Noisy/Loud Breathing			☐ Yes	☐ No	
	Shallow Breathing			☐ Yes	☐ No	
Other	Incontinent Urine/Stool			☐ Yes	☐ No	
	Drooling/Vomiting			☐ Yes	☐ No	

Form must be signed by health care provider and parent/guardian.
If you have any questions please call (502) 485-3387 or Fax: (502) 485-3670.
Please return to: Jefferson County Public Schools, Health Services, Lam Building, 4309 Bishop Lane, Louisville, KY 40218

_____ _____ _____ _____ _____

Printed Name of MD, APRN, or PA **Signature of MD, APRN, or PA** **Address** **Telephone No/Fax No** **Date**

*Parent/guardian hereby acknowledges that if this medication is not self-administered, it will most likely be administered by trained, unlicensed JCPS personnel. I acknowledge and agree when I authorize my child to attend a school sponsored field trip this medication and/or health service may also be administered by a licensed volunteer. By signing this form, the parent/guardian acknowledges that the Jefferson County Board of Education, its employees and agents shall incur no liability as a result of any injury sustained by the student from any reaction to any medication to treat a seizure or the administration of such medication, unless the injury is the result of negligence or misconduct on behalf of the school or its employees. The parent/guardian shall hold harmless the school and its employees against any claims made for any reaction to any medication to treat a seizure or the administration of such medication unless the reaction is due to negligence or misconduct on behalf of the school or its employees. Also, I hereby give permission for the healthcare provider completing and signing this form to verify this information with JCPS and to consult with JCPS staff regarding this behalf of the school or its employees.

_____ _____ _____

Signature of Parent/Guardian **Telephone Number** **Date**

****Parent/Guardian signature required only for INITIAL 2012-2013 PCP form. Parent/Guardian signature not required for updated 2012-2013 PCP forms.**

_____ _____ _____

Emergency Contact **Telephone Number** **Relationship**

December 27, 2011