Parent ☐
Physician ☐

Bullitt County Public Schools

1040 Highway 44 East
Shepherdsville, Kentucky 40165

Phone: 502-869-8000
Fax: 502-543-3608
www.bullittschools.org

SEIZURE PARENT PACKET

Dear Parent and/or Guardian;

I am sending home forms that will be used by school personnel in caring for your child's medical needs during the 2020-2021 school year. Attached is a seizure school action plan and medication permission form that will need to be completed **in full** with physician signature prior to bringing the medication to school.

The following conditions must be met before bringing medication:

- **Physician/Parent Authorization Form is complete and on file at school;**
- **Medication Permission Form is complete for each medication and on file at school;**
- **New medical forms must be updated each school year.**

As our policy 09.2241 states, "All prescription medication, original or refill, shall be brought to school in the most current pharmacy labeled container which includes the student's name, date, medication, dosage, strength, and directions for use including frequency, duration, and mode of administration, prescriber's name, pharmacy name, address and phone number. Labels that have been altered in any way shall not be accepted."

Please remember that the schools are not to administer any medication without proper paperwork and signatures on file. We appreciate your understanding and cooperation with this policy.

Sincerely,

Lesa A. Howell, RN

Lesa A. Howell, R.N. B.S.N.
District Health Coordinator
Bullitt County Public Schools

BULLITT COUNTY PUBLIC SCHOOLS

SEIZURE ACTION PLAN

School Year _____
Grade _____
School _____

Student's Name | Date of Birth

Parent/Guardian | Phone | Cell

Other Emergency Contact | Phone | Cell

Seizure Information

Seizure Type	Length	Frequency	Description

Known Triggers:
☐ Flashing Lights ☐ Computers ☐ Electronic Games ☐ Hormonal ☐ Emotional Stress or Anxiety ☐ Lack of Sleep ☐ Other _____

Warning Signs or Auras before a Seizure:
☐ Headache ☐ Vision Changes-blurred vision, double vision, spots, ☐ Blinking lights
☐ Body Temperature (Hot or Cold), ☐ Other: _____
Student's response after a seizure _____

Seizure Emergency Protocol (check all that apply & clarify below)
___Contact first aid responders
___Time event
___Monitor breathing
___Notify parent or emergency contact
___Administer emergency medication for seizure activity long than: ____3 minutes ____5 minutes
___Call 911 if emergency medication given or any condition listed in emergency box
___Notify health coordinator
____Other_____

Basic Seizure First Aid

*Stay calm & track time
*Do not restrain
*Remove hazards
*Keep child safe
*Do not put anything in mouth
*Stay with child & monitor until fully conscious

For tonic-clonic (grand-mal) seizure:
*Ease to the floor
*Keep airway open/watch breathing
*Loosen tight clothing at neck
*Protect head
*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

Treatment Protocol during School Hours (Medication dosage and instructions to be filled out on page 2 of seizure plan)

Does your child require emergency medication at school? _____ Yes _____No

Does the medication need to be transported to and from home? _____Yes _____No

Medication	Common Side Effects & Special Instructions	Medication to be kept: (please circle)
		Office / With Student / Classroom
		Office / With Student / Classroom

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 ___/___/___ Phone (_____) _____

I give permission for _____ to receive the above medication(s) at school according to standard
Student's Name
school policy and expressly hold harmless, and waive any liability on behalf of, the school or its employees and agents concerning any injuries or reactions resulting from administration or lack of administration of the above medication. For on-going medications, I understand that I have the ultimate responsibility for providing the school with an adequate supply of medication to enable orders from a physician or health care provider to be followed. I/We acknowledge that the school district shall incur no liability and I/We shall indemnify and hold harmless the school district and its employees against any claims relating to the self-administration or administration by school personnel of medications used to treat a seizure.

✕Parent/Guardian Signature _____ Date ___/___/___ Phone (_____) _____

Permission Forms for Medication

PHYSICIAN AUTHORIZATION FOR MEDICATION FORM

Student's Name: _____ Grade: _____ Age: _____ Date of Birth: _____/_____/_____

School: _____

COMPLETED BY THE PARENT/GUARDIAN AND HEALTH CARE PROVIDER

Procedure 09.2241 AP.1 – Medication shall be in the original container, dated upon receipt. Prescribed medication/self-administration/over-the-counter medication needed for longer than three (3) days requires a parent/guardian and Health Care Provider to complete the required form.

Name of Medication: _____ **Reason: _____ Stop date**: ___/___/___ or End of School Year **Time to be given: _____ Dose _____MG/ML/PUFFS/UNITS** **(please circle one)**	**Name of Medication: _____** **Reason: _____ Stop date**: ___/___/___ or End of School Year **Time to be given: _____ Dose _____MG/ML/PUFFS/UNITS** **(please circle one)**
Signs and symptoms of emergency administration: _____ Restriction and/or important side effects: _____ ***** Student must self-carry medication on his/her person and may self-administer. (Student will hold medication on their person for self-administration or for immediate access of school trained personnel.) ☐ Yes **(*MD to initial below)** ☐ No ***SPECIFIC TO FIELD TRIPS ONLY:*** *(*Please check 1 box*)* ☐ Trained personnel to assist student to self-medicate. (School personnel will hold medication until dosing time) ☐ ***** Student to self -carry and may self-administer. (Student will hold medication on their person for self-administration or for immediate access of school trained personnel) **(*MD to initial below)** ☐ Student requires medication to be administered (School personnel will hold medication and administer)	Signs and symptoms of emergency administration: _____ Restriction and/or important side effects: _____ ***** Student must self-carry medication on his/her person and may self-administer. (Student will hold medication on their person for self-administration or for immediate access of school trained personnel.) ☐ Yes **(*MD to initial below)** ☐ No ***SPECIFIC TO FIELD TRIPS ONLY:*** *(*Please check 1 box*)* ☐ Trained personnel to assist student to self-medicate. (School personnel will hold medication until dosing time) ☐ ***** Student to self -carry and may self-administer. (Student will hold medication on their person for self-administration or for immediate access of school trained personnel) **(*MD to initial below)** ☐ Student requires medication to be administered (School personnel will hold medication and administer)

PROVIDER SIGNATURE FOR ALL MEDICATIONS

_____ ___/___/___
Physician/Health Care Provider Signature Date

Physician Practice name: _____

Address: _____

Phone: (___) _____ Fax: (___) _____

***FOR SELF CARRYING/ SELF ADMINISTRATION ONLY**

_____***(MD INITIALS)** The above-named student has been instructed on the care, storage, dosage, and use (up to/and including getting help of trained personnel if student feels they are unable to administer the medication safely/effectively in an emergency situation) of the above medication(s) and has sufficient knowledge and ability to self-carry / self-administer the medication(s) in the school setting and while on field trips.

PARENT AUTHORIZATION FOR ABOVE LISTED MEDICATIONS

I give permission for _____ to receive the above medication(s) at school according to
Student's Name
standard school policy and expressly hold harmless, and waive any liability on behalf of, the school or its employees and agents concerning any injuries or reactions resulting from administration or lack of administration of the above medication. For on-going medications, I understand that I have the ultimate responsibility for providing the school with an adequate supply of medication to enable orders from a physician or health care provider to be followed.

Date: _____ *Signature:* _____ *Relationship:* _____

Home Phone: _____ *Work Phone* _____ *Emergency Phone* _____

I/we reviewed the statement and authorization for completion. ***Administrator/designee*** _____ Date ___/___/___

Review/Revised:12/16/2019

Consent Form for Mutual Exchange of Information

Student's Name: _____Date: _____

Date of Birth: _____ Social Security Number: XXX-XX-_____

Parent/Guardian: _____

Address: _____

I, the parent/guardian of the above-named student, hereby authorizes the mutual exchange of information including use and/or disclosure of protected health information and educational records between the Bullitt County Public School's District Health Coordinator and the physician, individual or organization listed below.

Physician, Individual, or Organization Name: _____

Address: _____Phone #: _____

The information will be used or disclosed upon request for the following purposes:

- □ Developing a medical plan for the student at school.
- □ Assessing the need for a medical transfer.
- □ Assessing the need for the student to access the Home Hospital Program.
- □ Addressing issues related to the student missing school/excessive absences.

Please allow consultation and/or forward documents to Bullitt County Public Schools:

- □ Addressing medical needs related to treatment for the following condition or injury _____ on or about _____.
- □ Including medical records covering the period of time _____ to _____.
- □ Reviewing or requesting any and all progress notes, care plan notes, and/or discharge notes to assess student needs, covering the period of time _____ to _____.
- □ Other: _____

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to the named physician/practice/organization and the Bullitt County Public Schools. I also understand that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization. I understand that if my healthcare provider is asking to use/disclose my information, I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, enrollment in any health plan, or payment/benefit eligibility. I may inspect or copy any information used/disclosed under this authorization. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by federal laws and regulations regarding the privacy of my protected health information.

This authorization expires on the following date or event: _____.

I certify that I have received a copy of this authorization. I further certify that I am the parent or legal guardian of the above-named student or that I am the student of majority age and have the authority to sign this release.

_____ _____ _____

Signature Relationship Date

34 CFR SEC 99.30 (Federal Family Educational Rights and Privacy Act of 1974) allows the release of certain records to third parties when:

1. Written consent is obtained from the parent, guardian, or student of legal age.
2. Written consent must: a. Specify the records to disclose. b. Purpose of disclosure. c. Identify whom disclosure made.
3. When disclosure is made: a. Parent or eligible student to receive a copy of records, if desired. b. Student to be provided a copy of the records disclosed, if parent requests.
4. Signed and dated written consent may include signature in electronic form if person is identified, authenticated and person's approval indicated.

Review/Revised: 3/23/2020