Primary Care Provider Authorization: Seizure Monitoring (Side One)

Student Name: _____Date of Birth: _____School/Site #: _____

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

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

_____

VNS should be kept in:

☐ Office ☐ Classroom ☐ Student backpack ☐ Other_____

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

Diastat should be kept in:
☐ Office or nurses office if applicable
☐ Classroom
☐ Student backpack
☐ Diastat should be transported on bus per student backpack and given if needed per orders.

Does this child have nutritional or dietary needs/restrictions due to seizures?
☐ YES ☐NO

Does this child take oral/g-tube/nasal medication?
☐YES* ☐NO
***IF YES, PLEASE COMPLETE THE AUTHORIZATION TO GIVE PRESCRIPTION AND OVER THE COUNTER MEDICATIONS FORM**
Please complete both sides of this form. Form must be signed by Health Care Provider and Parent/Guardian.

Emergency Plan of Action

1. Use vagal nerve stimulator (VNS) and/or rectal diastat as indicated.
2. Call EMS 911: 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, if administered diastat; and/or if t this PCP form indicates in writing to call at onset of seizure.
3. 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 911 will be called.
4. Notify school personnel trained in CPR/first aid to respond and initiate CPR if needed prior to EMS arrival.
5. Notify parent/guardian.
6. 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.
7. Document all seizure activity on the LCDHD Seizure Observation Record.
8. **If the student requires medical treatment while on the bus, the bus driver will contact EMS.**
9. Other:

_____
_____

Primary Care Provider Authorization: Seizure Monitoring (Side Two)

Student Name: _____Date of Birth: _____School/Site #: _____

Please specify likely characteristics.						**Comments/Other**
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/Check			☐ Yes	☐ No	
	Teeth Clenched			☐ Yes	☐ No	
Breathing	Noisy/Loud Breathing			☐ Yes	☐ No	
	Shallow Breathing			☐ Yes	☐ No	

_____ _____ _____ _____ _____

Printed Name of MD, ARNP, or PA **Address** **Signature of MD, ARNP, or PA** **Telephone No.** **Date**

***Parent/guardian hereby acknowledges that if this medication is not self-administered, it will most likely be administered by the school nurse or a trained, unlicensed school employee. By signing this form, the parent/guardian acknowledges that the local school district, its employees and agents and the Lake Cumberland District Health Department 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 school district/school nurse and to consult with school district staff regarding this information.**

_____ _____ _____ _____ _____ _____

Signature of Parent/Guardian **Telephone No.** **Emergency Contact** **Telephone No.** **Relationship** **Date**

Form must be signed by health care provider and parent/guardian. If you have any questions please call the local school or school nurse.
Please return to:

_____