ST. JOHNS COUNTY SCHOOL DISTRICT
HEALTH SERVICES

To the Parent/Guardian of: _____

School records specify that your child has a **SEIZURE DISORDER**.

In order to provide better health services for your child in school, we need to know if this is currently a problem and if your child needs special observation for this condition in school.

Please fill out and return this form to me at school. If you have any questions or concerns, please feel free to contact me at any time at _____. All medical information is confidential and will be shared only with the teaching staff working with your child. Thank you.

_____ _____
Name Title

What type of seizures does your child have?
_____Tonic-Clonic (grand mal) _____Partial _____Absence (petit mal)

When did your child have his/her first seizure? _____

Was it related to a specific event or illness, e.g. high fever? _____

Date of last seizure _____

How often do the seizures occur?_____

Is there an aura or warning sign just before the seizure? _____

Describe the seizure _____

How long does it last? _____

How does your child act after the seizure? _____

Are there any triggering or precipitating factors? _____

Is your child on any medication for the seizures? _____
Name of medication _____
When is it taken? _____

Has there been a recent change in the pattern of the seizures? _____

Who is your child's doctor? _____Last visit? _____

Are there any special instructions for school personnel? _____

_____

☐ **This is no longer a health problem for my child.**

_____ _____
Signature of Parent or Guardian Date

JOHNS COUNTY SCHOOL DISTRICT

HEALTH SERVICES

SEIZURE DISORDER MEDICAL MANAGEMENT PLAN

SCHOOL YEAR _____

Student Name: _____ Date of Birth: _____

Parent/Guardian: _____ Contact #'s: Home _____
Work _____
Cell _____

Parent/Guardian: _____ Contact #'s: Home _____
Work _____
Cell _____

Emergency Contact: _____ Contact #'s: Home _____
Work _____
Cell _____

Physician's Name: _____ Phone #: _____
Fax #: _____

Medications: (Please list all medications your child takes) _____

_____

_____

Does your child need medication during school hours? ☐ Yes ☐ No

If yes, please list: _____

(A Medication Authorization form must be completed for each individual medication and signed by both parent/guardian and physician.)

1. What type of seizures does your child have? _____
   _____
2. At what age did seizure activity begin? _____
3. Describe the seizure: _____
   _____
   _____
   _____
4. How often do seizures occur? _____
5. How long do the seizures normally last? _____
6. Has a seizure ever lasted longer than 5 minutes? ☐ Yes ☐ No
   If yes, how was it handled? _____
   _____
   _____

7. When was the last seizure? _____

8. Does your child lose bowel or bladder control during a seizure? ☐ Yes ☐ No

9. Has your child ever turned blue or stopped breathing during a seizure? ☐ Yes ☐ No
   If yes, how was it handled? _____
   _____
   _____

10. Has your child ever required hospitalization due to a seizure? ☐ Yes ☐ No
    If yes, please explain_____
    _____
    _____

11. Is there anything that seems to trigger a seizure? ☐ Yes ☐ No
    If yes, please list _____
    _____

12. Does your child experience an aura before a seizure? ☐ Yes ☐ No
    If yes, please explain_____
    _____

13. Are there any limitations to your child's activities? ☐ Yes ☐ No
    If yes, please describe _____
    _____

14. Does your child require protective equipment, (e.g. helmet)? ☐ Yes ☐ No
    If yes, please list and explain_____
    _____

Other considerations that will assist the school in providing safe care for your child:

_____
_____

Name of physician: (print/type) _____

Address: _____
_____

Signature of Physician: _____

_____ _____ _____
Parent/Guardian Signature Print Name Date

Revised July, 2011

ST. JOHNS COUNTY SCHOOL DISTRICT
HEALTH SERVICES

PARENT'S CONSENT AND RELEASE
FOR PROCEDURE RELATED TO INSERTION OF DIASTAT

I, the undersigned _____, have enrolled _____
(Parent / Guardian) (Student Name)
at _____. It is necessary for my child to have Diastat _____ mgs.
(Name of School)
in the event of seizure activity as described _____
OR for _____ or more seizures in _____ hours.

1. Give Diastat: at onset of seizure □ yes □ no
   OR at _____ minutes after onset of seizure.

2. When at school or on a field trip with trained school personnel:
   ***Call 911** at onset of seizure □ yes □ no
   OR at _____ minutes into seizure.
   OR at _____ minutes after Diastat is given if seizure activity is still present
3. Has your child ever received Diastat? □ yes □ no*
   If 1st time administration of Diastat is at school, 911 will be called at onset of seizure.

My permission is granted for personnel of this school and any school within the District, to which my child may transfer during the school year, including summer school, to carry out the procedure identified above. I understand that a physician's order for this treatment / procedure is necessary and is on file at school.

I specifically request that this treatment / procedure be administered by the school nurse or by members of the school staff who have been trained by the school nurse. I understand that these persons may not be medical personnel. I release the St. Johns County School District and any of its employees from all claims, demands, damages, actions, causes of action or suits at law or in equity, of whatsoever nature against the District and any of its employees for administering said treatment / procedure.

I also understand that I will be required to provide the Diastat and any equipment necessary to administer this medication. It will be maintained by me and delivered to the school in proper order.

In the event that a trained person is not available to perform the procedure, the protocol for 911 will be followec and parent will be notified.

_____ _____
(Signature of Parent / Guardian) (Date)

Emergency telephone numbers where the parent / guardian can be reached during the school day:

_____ _____ _____

_____ _____ _____

Revised July, 2011

ST. JOHNS COUNTY SCHOOL DISTRICT
HEALTH SERVICES

PHYSICIAN'S ORDER
FOR PROCEDURE RELATED TO INSERTION OF DIASTAT

Student Name _____ Date of Birth _____

School _____ Teacher / Grade _____

It is necessary for my patient to have Diastat _____ mgs. in the event of seizure activity as described
_____
_____
_____

OR for _____ or more seizures in _____ hours.

1. Give Diastat: at onset of seizure □ yes □ no
   OR at _____ minutes after onset of seizure.

2. When at school or on a field trip with trained school personnel:
   ***Call 911** at onset of seizure □ yes □ no
   OR at _____ minutes into seizure.
   OR at _____ minutes after Diastat is given if seizure activity is still present

1. Precautions, possible side effects for recommended intervention:
   _____
   _____
   _____

4. Treatment / Procedure is to be continued as above until _____ .
   (Date)

Physician's Name _____

Address _____

Telephone Number _____Fax Number _____

_____ _____
(Physician's Signature) (Date)

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ST. JOHNS COUNTY SCHOOL DISTRICT
HEALTH SERVICES

PROTOCOL FOR DIASTAT (RECTAL VALIUM)

Student Name _____ Date of Birth _____
School _____ Teacher / Grade _____

Persons Trained _____ _____
_____ _____
_____ _____
_____ _____

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1. Describe seizure activity indicating when Diastat is needed: _____
   _____
2. Call office or clinic and tell them of the emergency situation. Ask them to bring Diastat (Valium) from The clinic if it is stored there.
3. After seizure lasting _____ minutes, give Diastat _____ mgs. Per rectum following the established Procedure.
4. Have another person call E.M.S. (911):
   a. when Diastat is given [ ] yes [ ] no
   or b. _____ minutes after Diastat is given, if student is still seizing.
5. Record time seizure began and the time that the medication was given.

EMERGENCY CONTACTS:

Parent/Guardian _____ (H) _____
(Wk) _____
(Cell) _____

Parent/Guardian _____ (H) _____
(Wk) _____
(Cell) _____

Additional Emergency Contacts:

Name/Relationship _____ Phone _____

Name/Relationship _____ Phone _____

Physician_____ Phone _____
Fax _____

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ST. JOHNS COUNTY SCHOOL DISTRICT

AUTHORIZATION TO ASSIST IN THE ADMINISTRATION OF MEDICATION/TREATMENT

Student's Name: _____ Date of Birth:_____

School: _____ Grade: _____ Teacher/Homeroom: _____

NURSING SERVICES AND MEDICATION/TREATMENT ORDER

ALL INFORMATION MUST MATCH THE PRESCRIPTION LABEL! All medication must be properly labeled and in original containers. Complete one form for each medication/treatment to be administered. A new form must be completed if the dosage of a medication changes at any time.

Nursing services are recommended for the care of this student during the school day.

It is necessary for the following medication/treatment to be given in school and during school sponsored activities. I am aware that non-medical personnel may administer this medication/treatment.

Name of medication/treatment:_____Amount (Dosage):_____

Time to be given: _____Date to start: _____Date to end:_____

Health condition requiring medication: _____

Possible side effects: _____

Special instructions (i.e., may carry epi-pen/Glucagon on person)**: _____**

_____

Physician ordering medication: _____
(Print)

Physician's address: _____

Physician's phone: _____FAX: _____

Physician's signature: (required for all medications)_____

THIS SECTION FOR PARENT/GUARDIAN TO COMPLETE:

As the parent or guardian of the student named above, I request that the principal or principal's designee assist in the administration of medication/treatment prescribed for my child.

I understand that under provisions of Florida Statue 1006.062, there shall be no liability for civil damages as a result of the administration of medication when the person administrating such medication acts as an ordinarily reasonable, prudent person would have acted under the same or similar circumstances. I also grant permission for school personnel to contact the physician listed above if there are any questions or concerns about the medication. I have read the guidelines and agree to abide by them.

I authorize the physician to release information about this condition to school personnel.

_____	_____	_____
Parent/Guardian Signature	***Work/Home/Cell Phone***	***Date***

ASTHMATIC OR ALLERGIC STUDENTS: POSSESSION OF INHALERS OR EPIPENS — Florida Statute 1002.20

*Florida law states an asthmatic student or allergic student may carry a prescribed metered dose inhaler or epipen on his/her person while in school with approval from his/her parents **and** physician.*

The above named child may carry and self-administer his/her metered dose inhaler or epipen

Parent/Guardian Signature:_____ Date:_____

Physician's Signature: (required) _____ Date:_____