

Clinic Use **LOCATION OF EMERGENCY MEDICATION AT SCHOOL:** _____



SEIZURE
Health Management Plan
SCHOOL YEAR: _____

STUDENT NAME:	DOB:
SCHOOL:	STUDENT ID:

Parent/Guardian:	Parent/Guardian:
HOME/CELL #:	HOME/CELL #:
WORK #:	WORK #:
Other Emergency Contact:	Phone:
Neurologist:	Phone: Fax:
Hospital Preference:	

SEIZURE Type: _____ **Length:** _____ **Frequency:** _____ **Date of Last Seizure:** _____

Description of seizure(s): _____
Seizure triggers/warning signs: _____

STUDENT HISTORY (including other medical conditions):

DAILY MEDICATIONS (include name, dose, frequency):

EMERGENCY MEDICATION:

OTHER TREATMENTS OR CONSIDERATIONS:

<p>Basic Seizure First Aid</p> <ul style="list-style-type: none"> • Stay calm, observe, time • Keep student safe if wandering or confused • Stay with student until fully conscious • Record seizure activity • Contact parent 	<p>Tonic-Clonic (generalized) Seizure First Aid</p> <ul style="list-style-type: none"> • Call for clinic worker and remove bystanders • Turn on side, protect head, remove potentially harmful objects, do not restrain, put nothing in mouth • Keep airway open • Contact parent • Administer emergency medication as prescribed
--	---

CALL 911 if: seizure lasts > 5 minutes, emergency medication is administered, injury occurred or suspected, breathing does not return to normal, student has diabetes

Parent/Guardian signature indicates acknowledgment and release for sharing medical information between our student's physician and other health care providers and authorizing the designated school nurse to share medical information with other school employees as necessary.

Parent/Guardian Signature: _____ **Date:** _____

Provider Signature: _____ **Date:** _____

School Clinic: Copy of plan to be provided to Transportation Supervisor

 GCPS CLUSTER NURSE SIGNATURE/DATE



ADMINISTRATION OF MEDICATION REQUEST
(1 form per medication per student)

STUDENT NAME: _____ Date of Birth: _____
STUDENT NUMBER: _____ TEACHER: _____
SCHOOL: _____

For the safety of all students at our school, these guidelines should be followed:

- 1. Administration of prescription and over-the-counter medicine (even for a short period of time) is discouraged. Parents should check with their physician regarding the need for medications to be administered during school hours. Medications prescribed for three times daily often can be given before school, after school, and at bedtime. If you have any questions about this procedure, please call the school clinic.
2. All medications, both prescription and over-the-counter, must be accompanied by this form and brought to the school clinic by an adult.
3. All medications must be in the ORIGINAL CHILD PROOF CONTAINER. Prescription medications must be in the labeled prescription bottle. Pharmacists can give a duplicate labeled container with only the school dose. It is the responsibility of the parent/guardian to inform school of any changes and update medication forms. Medications stored in envelopes, baggies, etc., will not be administered. ALL MEDICATIONS NEED TO BE ADMINISTERED ACCORDING TO DIRECTIONS ON LABEL.
4. Medications must be picked up at the end of the year, or the school will dispose of them.

Name of Medication: _____ Expiration Date: _____
Reason Medication Given: _____
Amount to be Given: _____
Time(s) to be Given: _____
Possible Side Effects: _____
Special Instructions: _____

I, _____, grant permission for the principal or designee to assist in administration of medication listed above for my child, _____, while at school, or when on field trips.

I understand that the school personnel cannot assure that anything more than a reasonable effort will be made to assist the student and I further agree to waive any claims of liability that may rise against any school personnel relative to the administration of this medication to my child according to the instructions provided above.

Home: _____ Work: _____ Cell: _____

Signature of Parent _____ Date _____

FOR CLINIC USE: [] Medication disposed of By _____ Date _____
[] Medication picked up By _____ Date _____
(parent signature)