Howell Township Public Schools

PROUD OF OUR SCHOOLS CONCERNED FOR OUR CHILDREN

Dear Parent/Guardian,

Should it be necessary for your child to receive medication during school hours, you must present **this form** or an order from your personal physician, stating medication, **dosage**, **time of administration,** and the length of time your child will be on medication. This includes Tylenol, Motrin, cough drops and **all** over-the-counter medications. Any changes in these directions must be verified by a call to the school nurse, as well as a written note from the physician.

Any dangerous condition being experienced by a child on medication should be spelled out in detail with procedures to follow should a reaction occur. **Medicine must be properly labeled and in the original container, with the child's name, dosage, etc., on the pharmacist's label. The parent/guardian must transport all medication to and from school, unless a child has a doctor's signed permission to self-medicate and therefore carry an emergency medication (inhaler, pre-filled auto-injector mechanism).**

Sincerely,

Dorothea Fernandez

Dorothea Fernandez
Director of Pupil Services

Request for Administration of Medication

Student_____Homeroom_____Date _____

Diagnosis_____

Name of Medication_____Dosage _____Time of Administration _____

Daily or PRN: _____to be given_____ minutes before physical education or recess

To begin on _____ and conclude on _____

Possible side effects to be observed: _____

Special Instructions _____

Is this medication needed during field trips? Yes _____ No _____

Is this medication to be given on early dismissal day? Yes _____ No _____

Is child on any other medication? _____

Physician's Signature _____ Parent/Guardian Signature_____

School Physician's Approval _____ _____

Signature of Principal/Approval

PLEASE NOTE: If your child has permission from their physician to self-medicate with an emergency medication such as an asthma inhaler or a pre-filled auto-injector mechanism, please obtain the self-medication order form from your school nurse or download it from the district website.

Physician's Stamp

(2/2017)

HOWELL TOWNSHIP SCHOOL DISTRICT
EMERGENCY CARE PLAN for STUDENTS WITH SEIZURES

Pic

Student: _____ Date: _____
Birthdate: _____
Preferred hospital in case of emergency: _____
Physician: _____ Phone#: _____

Contact Information:

Parent /Guardian: 1. _____ 2. _____	**Home Phone:** _____ **Work:** _____ **Cell:** _____ **Work:** _____ **Cell:** _____
Emergency Contact:	**Home Phone:** _____ **Work:** _____ **Cell:** _____

PREVIOUS SEIZURE ACTIVITY INCLUDED _____

_____

_____

STUDENT -SPECIFIC EMERGENCIES

If You See This	*Do This*
Student is staring and/or unresponsive; possible repetitive movements; tensing or uncontrolled movements of any extremities.	**Remain with student. Have someone call for the nurse (ext: _____) immediately. Follow seizure protocol for teacher and staff (See reverse side).**
	For after school activities or if nurse is unavailable: **Remain with student. Have someone call 911 EMS immediately. Have someone contact administrator and parent. Follow seizure protocol (See reverse side).**

1. If the emergency is life-threatening, immediately call 9-1-1.
2. Stay with student or designate another adult to do so.
3. Call or designate someone to call the principal and/or the school nurse.
    a. State who you are.
    b. State where you are.
    c. State the problem.

School Nurse: _____ Phone: _____
Parent Signature: _____ Date: _____
Copy to: _____
_____

Howell Township Public Schools

PROUD OF OUR SCHOOLS CONCERNED FOR OUR CHILDREN

SEIZURE BUS EMERGENCY MEDICAL PLAN

NAME:_____

ADDRESS:_____

ROUTE #:_____

1. _____ has a history of **seizures.**

2. Seizures are sudden, uncontrolled episodes or excessive electrical discharges in some nerve cells of the brain, with associated sensory, motor, and/or behavioral changes.

3. The two major groupings of seizures are generalized seizures and partial seizures. Generalized seizures may involve the entire body or present as staring spell or blinking of eyes. Partial seizures may involve only parts of the body and/or confusion.

4. _____ previous seizure activity included _____
_____

5. If _____ has any seizure activity:

   A. Radio for help. Ask for 911 emergency response to meet you at your location. Tell the dispatcher: "I am transporting a _____ year old child with a history of seizures. His/her symptoms are _____.
   B. Stay with the child, speak calmly, and reassure him/her that people are coming to help.
   C. The student should be placed on their side across the seat with his/her head facing toward the aisle and facing away from the back of the seat. Alternatively, the student can be placed on one side in the aisle.
   D. When student is transported to hospital send this form with emergency telephone numbers.
   E. Make sure that your bus company contacts the parents and the school to inform which hospital the child has been transported.
   F. Fill out any accident/incident report that is required.
   G. If you have any questions, please contact the school nurse at _____. Also, please keep in close communication with the school nurse throughout the year with any changes that may occur with the bus run as the year progresses.

6. The student will be seated at the front of the bus to the right of the bus driver. _____ _____
Accept *Decline*

_____ _____ _____ _____
Certified School Nurse *Date* *Bus Driver* *Date*

_____ _____
Parent/Guardian Signature *Date*

EMERGENCY CONTACTS

1. Name:_____ Relationship:_____ Phone No:_____

2. Name:_____ Relationship:_____ Phone No:_____

(August 2011)

INDIVIDUALIZED HEALTH CARE PLAN

NAME:_____ DOB:_____ SEX:___ ALLERGIES:_____ PHYSICIAN:_____

Parent Signature _____ School Nurse Signature _____

Date	Health Problem/Nursing Diagnosis	Student Goals	Intervention and Responsible Person	Evaluation and Timeline
	Potential for injury Related to uncontrolled movements during seizure	Prevent injury during seizure	Protect child during seizure and educate staff in same measures. All staff needs to know appropriate response to a child having a seizure to prevent injury.	Student will not experience injury during a seizure.
			Establish appropriate activity restrictions in cooperation with parents and physicians, based on real rather that perceived risk. Certain activity restrictions may need to be imposed to prevent injury during a seizure. Restrictions to be reassessed periodically. _____ is not to climb any heights.	At this time _____ is not to climb any heights.
			First aid and emergency care as needed. Procedures for first aid should be established and known by school personnel. Emergency plan to teachers in the need to know for educational purposes.	All teachers given poster with directions of what to do during a seizure
			Provide documentation of seizure activity during school and communication to parents and healthcare providers as appropriate. Include date, time, duration, objective facts about seizure behavior and observer's name. Staff to be provided with seizure flow sheet and seizure log and to regularly communicate with nurse and parents. Emotional support to students and staff.	Staff given documentation flow-sheets.
	Potential for aspiration	Prevent aspiration during seizure	Position child on his/her side and if possible to prevent aspiration. Clear secretions from mouth if necessary.	Student will not aspirate during a seizure.