

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
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 _____

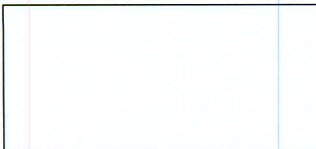
Is child on any other medication? _____

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

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

PREVIOUS SEIZURE ACTIVITY INCLUDED _____

STUDENT -SPECIFIC EMERGENCIES

<i>If You See This</i>	<i>Do This</i>
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: _____

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
	<p>Potential for injury Related to uncontrolled movements during seizure</p>	<p>Prevent injury during seizure</p>	<p>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.</p> <p>Establish appropriate activity restrictions in cooperation with parents and physicians, based on real rather than 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.</p> <p>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.</p> <p>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.</p> <p>Emotional support to students and staff.</p>	<p>Student will not experience injury during a seizure.</p> <p>At this time _____ is not to climb any heights.</p> <p>All teachers given poster with directions of what to do during a seizure</p> <p>Staff given documentation flow sheets.</p>
	<p>Potential for aspiration</p>	<p>Prevent aspiration during seizure</p>	<p>Position child on his/her side and if possible to prevent aspiration. Clear secretions from mouth if necessary.</p>	<p>Student will not aspirate during a seizure.</p>