**HEALTH SERVICES**
Richardson Independent School District
**Annual Health Services Prescription**
**Provider/Parent Authorization for Seizure Management**
*This form to be renewed annually and as there are significant changes in the student's medical condition (i.e. surgical intervention, etc.)

Student: _____ Date of Birth: _____Sex: _____Grade:_____

**TO BE COMPLETED BY THE PROVIDER**

The parent/guardian of the above named student has notified the school that this student has a history of seizures and may require the use of Diastat®, and/or other interventions at school. Please complete this form based on your examination and knowledge of this student and sign in the space provided.

Diagnosis: _____ Student weight _____kgs

Probable signs/symptoms of seizure activity for this student include:

- ☐ Aura: _____
- ☐ Eyes moving upwards/to side in rapid or "rolling" movements
- ☐ Inattentiveness or appearing to be "daydreaming"
- ☐ Inability to speak or garbled speech
- ☐ Other: _____
- ☐ Other: _____
- ☐ Jerking or stiffening of extremities
- ☐ Sudden loss of muscle control (such as dropping to the floor or dropping objects)
- ☐ Facial grimacing, lip smacking, or drooling
- ☐ Loss of consciousness
- ☐ Other: _____
- ☐ Other: _____

Medications currently prescribed for seizure management:

| Medication | Dosage | Route of Administration | Frequency |
|---|---|---|---|
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In the event of a seizure at school, the following seizure protocol will be followed (in addition to measures indicated by provider in sections below with regard to Diastat administration and Vagus Nerve Stimulators):

1. Assess respiratory status; if child is not breathing, call 911.
2. Keep calm - let seizure run its course. DO NOT GIVE CPR during the seizure
3. DO NOT attempt to restrain or force object between teeth
4. Ease child to floor if possible and remove objects from around the student which may cause injury
5. Turn the student on his/her side if possible to prevent aspirating saliva
6. Loosen tight clothing and place something soft and flat under his/her head
7. Note the time, duration, characteristics of the seizure activity
8. Monitor breathing, watch for turning blue around the mouth
9. Monitor seizure activity
10. Attempt to contact the parent

Per RISD Protocol, **911 will be called for seizures lasting longer than 5 minutes**. In addition, 911 will be notified if indicated by the provider for _____ or more seizures within _____ minutes / hours.

**COMPLETE THIS SECTION IF THE STUDENT HAS AN ORDER FOR DIASTAT**

Diastat® (diazepam rectal gel) dosage: _____ mg rectally PRN for:

- ☐ Continuous seizure longer than _____ minutes
- ☐ For _____ or more seizures within _____ minutes / hours

Please note: 911 will be called if Diastat® is administered.

Side effects that can be expected after administration of Diastat® are:_____

_____

Action to be taken if student has a bowel movement or expels the Diastat®:_____

*Please continue to next page for provider signature.*

**COMPLETE THIS SECTION IF THE STUDENT HAS A VAGUS NERVE STIMULATOR (VNS)**

Date implanted: _____ Date activated: _____ Type of Magnet: ☐ Watch-style ☐ Pager-style

List the standardized procedure(s) to be performed: _____

Special instructions regarding this procedure (Please attach facility protocol, if applicable) _____

_____

How frequently during the school day could the magnet be used (ex: once every hour)? _____

Side effects and interventions should side effects occur: _____

_____

Specific instructions on utilizing the magnet:
- ☐ Pass magnet in a cross fashion over Pulse Generator
- ☐ Lay the magnet on the Pulse Generator for a total of _____second(s)
- ☐ Other directives _____

Under what conditions should the magnet be attached to the Pulse Generator to stop stimulation: _____

_____

What type of equipment should the parent provide in order for this procedure to be performed? _____

_____

FOR SELF-ADMINISTRATION OF VNS ONLY

Does this student recognize the onset of his/her seizure? …… ☐ Yes ☐ No

Can this procedure (re: VNS) be safely administered by the student in the school setting? …… ☐ Yes ☐ No

This student has been provided instruction/supervision and is capable of performing the above procedure. …… ☐ Yes ☐ No

Does this student need the supervision of a designated adult? …… ☐ Yes ☐ No

*Please attach a copy of any medical and developmental history that may be pertinent to the therapy program.

**Provider's Signature**: _____ **Date**: _____

Provider's Name (please print): _____ Phone: _____

Address: _____ Fax: _____

**TO BE COMPLETED BY THE PARENT:**

My child rides the bus to/from school. ☐ Yes ☐ No

In the event that I am unavailable or unable to pick up my child after Diastat® has been administered, or for a prolonged postictal period (per student's IHP), my child may be released to the following emergency contacts:

1. _____ Relation to child: _____ Phone: _____
2. _____ Relation to child: _____ Phone: _____
3. _____ Relation to child: _____ Phone: _____

I, the undersigned, the parent/guardian of _____ request that the above named specialized physical health care service to be administered to my child. I understand that it is my responsibility to provide the necessary equipment and supplies in order for the above healthcare service(s) to be performed at school by district personnel. I understand that the school administration will appoint a qualified designated person to perform the above mentioned health care service. It is my understanding that in performance of the service, the designated person(s) will be using a standardized procedure that has been approved by the provider. I will notify the school immediately if the health status of my child changes, I change providers, or the procedure is canceled or changed in any way. I understand that it is my responsibility to provide the school with the medications and supplies needed to perform the above procedure(s). I also give my consent to release medical/health records and permission to appropriate school staff to contact the physician/health care provider for additional information if needed.

Parent's Signature: _____ Date: _____

**HEALTH SERVICES**
Richardson Independent School District

Dear Parent/Guardian:

In an effort to serve your child safely and effectively in the school setting, enclosed are forms that are required by RISD to be completed by you and/or your child's medical provider. These forms must be renewed annually.

**The following forms will be required and are included in this packet:**

- *Seizure History Parent Questionnaire*
- *Provider/Parent Authorization for Seizure Management*
- *Parent/Provider Request for Administration of Medication by School Personnel.* Every medication must have a medication form completed. The provider's signature is not required on the form(s) **if** the medication is a prescription with the correct student name, dose and a date within the calendar year on the label. The label should describe how often the medication is to be given and under what circumstances.

Thank you,

RISD Health Services

**HEALTH SERVICES**
Richardson Independent School District
# Seizure Health History Parent Questionnaire

Please complete all questions. This information is essential for the school nurse and school staff in determining your student's special needs and providing a positive and supportive learning environment. If you have any questions about how to complete this form, please contact the school nurse.

Student Name: _____ Date of Birth: ___/___/___ School Year: _____

School: _____ Grade: _____

| **Emergency Contact Information** | | Home: | Work: | Cell: |
|---|---|---|---|---|
| Parent/Guardian: | | | | |
| Parent/Guardian: | | | | |
| Other: | | | | |
| Neurologist: | | | | |
| Primary Doctor: | | | | |

## Seizure Information

When was your child diagnosed with seizures or epilepsy? _____

Seizure type(s)

| Seizure Type | Average Length | Frequency | Description |
|---|---|---|---|
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What might trigger a seizure in your child? _____

Are there any warnings and/or behavior changes before the seizure occurs? …….. ☐ YES ☐ NO

If YES, please explain: _____

How often does your child have a seizure? _____ x a day _____ x a month Other: _____

When was your child's last seizure? _____

In the past year, have there been any changes in your child's seizure patterns? …… ☐ YES ☐ NO

If YES, please explain: _____

How does your child react after a seizure is over? _____

How do other illnesses affect your child's seizure control? _____

## Basic First Aid: Care & Comfort Measures

The box at right shows standard first aid procedures that will be implemented in RISD for a student having a seizure. Are there additional actions that should be taken when your child has a seizure in school? …… ☐ YES ☐ NO

If YES, please explain: _____

_____

_____

Will your child need to leave the classroom after a seizure? …..... ☐ YES ☐ NO

If YES, what process would you recommend for returning your child to the classroom?

_____

_____

**Basic Seizure First Aid:**
- ✓ Stay calm & track time
- ✓ Keep child safe
- ✓ Do not restrain
- ✓ Do not put anything in mouth
- ✓ Stay with child until fully conscious
- ✓ Record seizure in log

**For tonic-clonic seizure:**
- ✓ Protect head
- ✓ Keep airway open/watch breathing
- ✓ Turn child on side

Student Name: _____ Date of Birth: ___/___/___ School Year: _____

## Seizure Emergencies

The box at right lists seizure situations that are generally considered to be emergencies. Please describe what constitutes an emergency for your child. (Answer may require consultation with treating physician and school nurse.)

_____

_____

**A seizure is generally considered an emergency when:**

- Convulsive (tonic-clonic) seizure lasts longer than 5 minutes
- Student has repeated seizures without regaining consciousness
- Student is injured or has diabetes
- Student has a first-time seizure
- Student has breathing difficulties
- Student has a seizure in water

Has child ever been hospitalized for continuous seizures? …….. ☐ YES ☐ NO

If YES, please explain: _____

_____

_____

## Medication and Treatment Information

What medication(s) does your child take?

| MEDICATION | DOSAGE | FREQUENCY & TIME OF DAY TAKEN | POSSIBLE SIDE EFFECTS |
|---|---|---|---|
| | | | |
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What emergency/rescue medications are prescribed for your child?

| MEDICATION | DOSAGE | HAS THIS EVER BEEN ADMINISTERED TO YOUR CHILD? HOW MANY TIMES? |
|---|---|---|
| | | |
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Does your child have a Vagus Nerve Stimulator? …… ☐ YES ☐ NO

## Special Considerations & Precautions

Does your child wear a "medical alert" necklace/bracelet? ..... ☐ YES ☐ NO

Is your child participating in sports or school sponsored extra-curricular activities? ……. ☐ YES ☐ NO

If YES, please explain: _____

Is your child comfortable alerting others when experiencing symptoms of a possible seizure? …….. ☐ YES ☐ NO

What are your child's feelings about having a seizure disorder? _____

_____

_____

Check all that apply and describe any consideration or precautions that should be taken:

☐ General health: _____ ☐ Physical education: _____

☐ Physical functioning: _____ ☐ Recess: _____

☐ Learning: _____ ☐ Field trips: _____

☐ Behavior: _____ ☐ Bus Transportation: _____

☐ Mood/coping: _____ ☐ Other: _____

What is the best way for us to communicate with you about your child's seizure(s)? _____

Parent's Signature:_____ Date: _____

2020-2021

**HEALTH SERVICES**
Richardson Independent School District

# Parent/Provider Request for Administration of Medication by School Personnel

**Date of Request:**_____ **School:**_____ **Teacher/Grade:** _____

**Student's Name:**_____ **Birth date:**____/____/____

**Medication:**_____ **Exp. Date**____ **Dosage:** _____

**Route of administration:** ☐ by mouth ☐ inhaled ☐ topical ☐ eye(s) ☐ ear(s) ☐ nasal ☐ injection (circle: IM SQ IV) ☐ rectal ☐ GT/JT

**Time to be Administered:**_____ **Dates to be Administered:** _____

**Condition for which medication is required:** _____

**Has your child ever taken this medication before? YES NO**

**Medication Allergies:** ☐ No Known Medication Allergies ☐ Allergic to: _____

**Special Instructions or known Side Effects of medication on your child:** _____

_____

**Please indicate how you would like the medication to be returned home when the medication order expires**:

☐ Send home in my child's backpack* ☐ Parent/Guardian will pick up med from clinic ☐ Do not return med, please discard any remaining doses

**Controlled substances (such as Ritalin, amphetamine salts, etc.) must be transported by a parent/guardian and will not be released to students.*

The district will take reasonable measures to store medication at ambient room temperatures unless refrigeration is required. Parents must take home medications during school breaks to avoid exposing medications to extreme heat or cold.

My signature below indicates that I request that RISD staff administer the medication specified above to my child, and I am giving permission for RISD staff to contact the physician for additional information, if needed. I understand that for prescription medications, only a 30-day supply will be accepted at a time.

**Parent/Guardian Signature:**_____ **Email:** _____

**Parent's Primary Phone:** (____)_____-_____ **Alternate Phone:** (____)_____-_____

**Provider's Name:**_____ **Phone:** (____)_____-_____

**A provider's signature is required to administer over-the-counter medications for more than 10 consecutive school days from the date of the original request. Medications with a printed pharmacy label for the student do NOT require the provider's signature below.*

***Provider's Signature:** _____

***FOR OFFICE USE ONLY!*** ☐ Entered in Focus ☐ Teacher Notified___/___ ☐ IHP in Focus & eStar (if applicable)

**Prescription Medication Count:**

| Date | # Pills | Counter's Signature | Witness Initials | Date | # Pills | Counter's Signature | Witness Initials |
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**Comments (Indicated by * on back of form):**

| Date | Comments | Date | Comments |
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| Date | RN Review |
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Medication returned to: Parent / Student _____ Date _____
Parent/Student Signature

**STUDENT NAME:** _____ **MEDICATION:** _____

**DOSAGE:** _____ **TIME:** _____

| DAY | AUG | SEPT | OCT | NOV | DEC | JAN | FEB | MAR | APR | MAY | JUNE | DAY |
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| DAY | AUG | SEPT | OCT | NOV | DEC | JAN | FEB | MAR | APR | MAY | JUNE | DAY |

**CHARTING CODES**

| A | DC | FT | H | OOM | R | * |
|---|---|---|---|---|---|---|
| Absent | Discontinued | Field Trip | Hold | Out of Medication | REACH | Comments |

* Indicates Comments on front of form