Mecklenburg County Health Department
School Health Program

SEIZURE EMERGENCY ACTION PLAN Name: ______________________

School: ______________ Year: ________ Grade: _____ Date of Birth: ____________ Allergies: __________

Homeroom Teacher: ______________________ Room: ________ Student ID #: ________________

Parent/Guardian: ______________________________ Ph. (H): ______________________

Address: ______________________________ Ph. (W): ______________________

Parent/Guardian: ______________________________ Ph. (H): ______________________

Address: ______________________________ Ph. (W): ______________________

Emergency Phone Contact #1: ______________________ ____________ ____________

Name Relationship Phone

Emergency Phone Contact #2: ______________________ ____________ ____________

Name Relationship Phone

Physician treating student for seizure disorder : ______________________ Phone: ______________

Other Physician: ______________________________ Phone: ______________________

Preferred Hospital: ____

EMERGENCY PLAN

(Fill in blanks, cross out and initial any steps not needed for this student.)

Emergency action is necessary when the student has the following symptoms: ______________________

____

Steps to take during a seizure:

1. Stay with student during and after seizure. Note duration of seizure and type of body movement during seizure episode.
2. Assist to lying position if loss of consciousness occurs. Remove glasses if wearing, loosen clothing around neck.
3. Turn on side as soon as possible.
4. Clear area around child to prevent injury; remove other students from area if possible.
5. **DO NOT RESTRAIN MOVEMENT OR PLACE ANYTHING IN MOUTH.**
6. Monitor breathing and begin artificial respiration if breathing does not resume spontaneously.
7. Call 911 if seizure lasts longer than 5 minutes, the student has one seizure after another without waking or there are signs of significant injury or physical/respiratory distress. If 911 is called, transport to ______________________________ Hospital.
8. When seizure is over, allow child to rest and always notify parent/guardian.
9. Notify school nurse.

Other instructions for this student: ______________________________

____

Daily Seizure Management Plan:

1. What type of seizures does your child have and how often do they occur? ____________________

   ____

   Date of last seizure: ____

2. Describe your child's symptoms during and after a seizure episode. ____________________

   ____

3. Does your child have an aura or warning of a seizure coming? Yes __ No __

   Is he/she able to notify anyone that a seizure is coming? Yes __ No __

4. Name medications taken routinely. How often and how much?

   At home: ____

   At school: ____

   Does your child experience any side effects to these medications? Please list:

   ____

   Are there any sports/activities in which your child CANNOT participate?

   ____

*** PLEASE NOTE: If medications are to be taken at school, a Medication Authorization form must be completed by the parent and physician and kept at the school.**

Parent/Guardian Signature: ________________________________ Date: ____________

School Nurse Signature: ________________________________ Date: ____________

<u>This information will be shared with appropriate school staff unless you state otherwise.</u>

Important Information about Medication Admininstration in CMS Schools (7/31/2017)

School Name	School Phone #	Fax:	For School Use Only
		(704) 432-2079 (School Health)	Date Received/Receiver's Signature: Medication Received? ☐ yes ☐ no
Student's Name (Please print.)	Student's Date of Birth		Date Approved/Nurse's Signature Entered in EHR? ☐ yes ☐ no
Parent/guardian completes this form when medications are ordered on a form that is not the "Medication Authorization for CMS Students (version 04/25/17 ml)". Parent/Guardian: Please read the information below. Fill in the contact information for your child's healthcare provider and parent/guardian contact information. Sign and date the form.			☐ Medication in Health Room ☐ Student Self Carries ☐ Emergency Medication in Classroom

Important Information about Medication Admininstration in CMS Schools

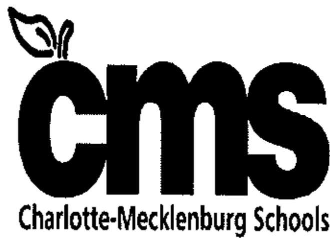
- When possible, medications should be taken before or after school. Administration of non-prescription medications at school is discouraged.
- Written parent/guardian consent and an order from a healthcare provider licensed in North Carolina are required for administering prescription and over-the-counter medications at school (CMS Policy JLCD/Regulation JLCD-R). Contact the school nurse for help if relocating from another state with orders from an out-of-state provider. Some medications may not be suitable for a school setting. Additional documentation may be required for some medications (examples: research medications, medications with potential for immediate serious side effects). Contact the school nurse if you have questions.
- No medication will be given at school until the Medication Authorization form completed by the healthcare provider has been approved by a school nurse.
- Medications are given by a nurse or trained CMS staff.
- Unless changed in writing, medication orders will be used for the entire school year within which it was written.
- New authorization forms are required at the beginning of every school year, when the dose or directions change, and when a new medication is prescribed. Parents/guardians must supply the medications.
- Each medication must be in the original labeled container from the pharmacy or healthcare provider's office. Some pharmacies will provide an extra container for school use.
- Information about this medication and the student's health may be shared with other school staff or agents of the school to help assure the student's safety and success at school.
- The school nurse may contact the healthcare provider who prescribed the medication and the pharmacy where the prescription was filled to discuss this medication and the student's health.

Healthcare Provider's Name / Address / Phone / Fax	Parent/Guardian Contact Information (please print)	
	Parent/Guardian	
	Phone:	Phone:
	Parent/Guardian	
	Phone:	Phone:

I have read and understand the "Important Information about Medication Administration in CMS Schools". I give permission for my child to receive the medications ordered by the healthcare provider during school hours. I give permission for the healthcare provider, pharmacist and their staff to provide information to the school nurse about my child's medication(s) and health. On behalf of my child, I release the Charlotte-Mecklenburg Board of Education, their agents and employees from any and all liability whatsoever that may result from my child taking the medication(s) at school.

Write on line below.

Parent's/Guardian's Name (print) ______ Signature ______ Date ______



Mecklenburg County Health Dept

SCHOOL HEALTH SERVICES
A Partnership for Serving Children

Order: Diastat in School

Student's Name: ______________________________ DOB: __________________
Student's Address: ____
Student's Phone #: _____________________ Student's I.D: ____________________
Mother's Name: _______________ Phone: Work _____________ Cell _____________
Father's Name: _______________ Phone: Work _____________ Cell _____________
Preferred Hospital: ____
School: _JOSEPH W. GRIER ACADEMY_ Teacher/Grade/Homeroom: ______________

Student's Diagnosis: ____

Please have the student's Health Care Provider complete the following information:

1. Observe seizure activity and time the seizure.
2. If seizure is longer than _____ minutes in duration give Diastat _____ mg. rectally as ordered following proper procedure.
3. Monitor vital signs.
4. Assess student for specific behaviors and movements during the seizure and complete the seizure flow sheet. Remain with the student.
5. Notify parent/guardian. Student must be picked up from school.
6. Observe for decreased breathing or heart rate, change in color, head injury at time of seizure, duration and number of seizures.
7. Call 911 if:
8. Document medication given on medication record.
9. Other:

Duration of order: School Year_2020-2021_

Health Care Provider ____________________ Phone # _____________ FAX # _____________
Address: ____
Health Care Provider's Signature: ________________________________
Date: ______________
(Please sign here to authorize this order and return to the School Health Program, MCHD, 3205 Freedom Drive, Suite 8500-Building K Charlotte, N.C. 28202 Fax: 704-432-2079 Attn: School Health.)

I have reviewed this order and give my permission for the School Health Nurse to train school personnel to follow this order.
Parent /Guardian Signature__________________________________ **Date**_____________
I have provided training and instruction regarding this order to: ____________________________
(Signatures of personnel trained)

____, ____

____

School Health Nurse Signature__________________________________ **Date**_____________