Boone County Schools
School Health Services Department

Seizure Health Care Plan

Plan Date: _____

Student Name: _____ **Date of Birth**: _____ **Grade**: _____

Seizure appearance and length	Seizure triggers or warning signs:	Response after a seizure:

Does the student have a Vagal Nerve Stimulator? ☐ NO ☐ YES, describe magnet use:_____

_____

Are medications needed to control seizures? ☐ NO ☐ YES, please list medications below.

Medications	**Dose**

Basic Seizure First Aid	**Seizure Emergency First Aid**
• Stay calm & Time the seizure • Keep child safe • Do NOT restrain • Do NOT put anything in the mouth	• Contact school nurse • Administer emergency medications - **Only RN may administer Versed provided by parent** • Call 911 • Contact parent/ guardian

Special considerations, precautions, instructions:

_____

_____

Physician Signature: _____ **Date:** _____

Parent Signature: _____ **Phone Number:** _____

School Nurse Use Only		
_____ Stable _____ Potential complications _____ High risk	_____ Standard seizure procedure _____ Standard school medication _____ Individual HCP	Review Date: _____ Nurse Signature: _____
_____ Delegated or assigned caregiver name and date trained _____		

Revised: Nov. 2018 SLW

Boone County Schools
School Health Services Department

Medication Administration Consent Form

In-school/ After-school hours/ Field trip (including self–administration)

Prescribed medications (including herbal and dietary supplements) and over the counter medications shall be given according to the instructions below. All prescription medication MUST be in the original pharmacy container, labeled with student name, prescribing healthcare provider, strength and dose of medication and directions for use, including a time(s) for dosing. Over the counter medications MUST be in their original containers. No more than one week's supply of prescription medication may be received at school; for a field trip, only the amount of medication required for the event will be accepted. Please refer to Boone County Schools medication policy and procedures for more detailed information. This consent is only valid for the current school year.

Student's Name: _____ **Date of Birth:** _____ **Grade:** _____

Allergies: _____

****Please advise the school nurse immediately of any changes in medication or dosing.****

Medication 1: _____ Diagnosis/ Condition: _____

Dose (mg/ml): _____ Route: _____ Administration time(s): _____

Possible side effects: _____

**** In the case of emergency medication (inhaler, epinephrine, glucagon, or FDA approved seizure medication) this student has received training, and is capable of the following:**

Physician's initial in appropriate box(s)	_____ may **CARRY** medication	_____ may **SELF-ADMINISTER** medication

Medication 2: _____ Diagnosis/ Condition: _____

Dose (mg/ml): _____ Route: _____ Administration time(s): _____

Possible side effects: _____

**** In the case of emergency medication (inhaler, epinephrine, glucagon, or FDA approved seizure medication) this student has received training, and is capable of the following:**

Physician's initial in appropriate box(s)	_____ may **CARRY** medication	_____ may **SELF-ADMINISTER** medication

Specific to field trips: In the case of field trips or school-related functions, slight adaptations to medication administration times may be necessary. Unless otherwise indicated, student may self-administer medication with school-trained personnel while on an in-state or out-of-state field trip.

I request trained Boone County School employees to administer or supervise the administration of this medication in accordance with Boone County Schools' Medication Administration Guidelines and the above instructions. I release Boone County School District and any of its employees (hereinafter the "District") from any liability or harm which is suffered by the student (named above) as a result of this request. I further agree to indemnify and hold the District harmless from any legal action or other attempts to acquire compensation, including damages and legal and medical fees, from the District whenever the District has acted in accordance with the information provided by my child's physician.

Trained Unlicensed School Personnel: The Boone County Board of Education has adopted a procedure in which a staff member, from the school the child is attending, will administer either an injection, prescribed medication or other emergency procedure in the event of a crisis. The undersigned understands that the staff member administrating the above care may not be a licensed healthcare professional, but that this staff member will undertake to do his or her best to comply with the procedure as developed by the student's physician in the case of a life threatening emergency wherein immediate intervention is required.

Parent/ Guardian signature: _____ **Date:**_____

Physician signature: _____ **Date:** _____

Physician name: _____ **Phone number:** _____

Staff administering medication are trained annually by a registered nurse.

Student's Emergency Medication Location	
☐ First Aid Room	☐ Self-carries; Location: _____

Boone County Schools
Student Services Division
School Health Services Department
Transportation/Student Health Concerns

Photo

School Year: _____

Student Name: _____

Address: _____

Bus Number: _____ **School:** _____

Date of Birth: _____ **Age:** _____ **Grade:** _____

Health concern of student: _____

Medication/supplies which will be with student during bus transportation: _____

_____

Is student responsible for medication administration? Yes ☐ No ☐

Emergency care to be given to student by bus driver: _____

_____

Comments: _____

Parent /Guardian signature: _____

Daytime phone number: _____ Date: _____

This completed form must be returned to your child's school office in order for transportation to be notified.

School nurse is to scan completed form to Transportation: cynthia.buttery@boone.kyschools.us

Revised: Sep. 2019 SLW