Primary Care Provider Authorization: Seizure Monitoring (Side One)

Student Name: ______________________ Date of Birth: ______________________

School: __________ Grade: __________ School Year: ______________________

Type of Seizure: ☐ Grand Mal (Tonic-clonic) ☐ Petit Mal (Absence) ☐ Complex Partial ☐ Other________

IF child has **VAGAL NERVE STIMULATOR** please specify when to use and how often (i.e. Q minute X 4 then administer diastat): ______________________

IF child has **DIASTAT**, please specify: **DOSE: ________MG PER RECTUM AND ADMINISTER AT:**

☐ Onset of seizure ☐ 5 minutes after onset of seizure ☐ Other: ______________________

Diastat should be kept in the office.

*** Diastat will NOT be transported on the bus unless parent/guardian makes prior arrangements with the school. If Diastat is to be transported, the student will be placed on a Special Needs bus & parent will need to provide a Diastat kit to the school WITH this completed form.**

Does this child have nutritional or dietary needs/restrictions due to seizures? ☐ YES* ☐ NO

***IF YES, PLEASE COMPLETE SWALLOWING/FEEDING DISORDER PRIMARY CARE PROVIDER AUTHORIZATION FORM**

In the event of generalized tonic clonic/ grand mal seizure, the following observations and monitoring procedures will be followed by school staff:

- Ease student to the floor (unless harnessed securely in wheelchair and breathing is not restricted).
- Remove hazards in the area, such as, sharp or hard objects, to prevent further injury.
- Loosen tight clothing at the neck.
- Turn student onto his/her side to allow saliva to drain and to keep airway open.
- Cushion the student's head with something soft.
- Monitor student while the seizure runs its course and speak to him/her in calming tones.
- Following the seizure, allow the student to rest as needed in a quiet supervised area.
- Following each occurrence, report activity to parent/guardian in writing and by telephone.

EMERGENCY PLAN OF ACTION

1. Use vagal nerve stimulator (VNS) and/or rectal diastat as indicated.
2. Call EMS 9-911: if any seizure lasts longer than five minutes; if there is any continued, progressive respiratory distress; if another seizure starts right after the first; if school has no record of student history of seizures, if administered diastat; and/or if this PCP form indicates in writing to call at onset of seizure.
3. Notify school personnel trained in CPR/first aid to come stay with student and initiate CPR if needed prior to EMS arrival.
4. Notify parent/guardian.
5. If student needs to be transported via EMS, WCPS staff must ride with student unless parent and/or emergency contact accompanies them. .
6. Other: ______________________
7. Other: ______________________

Please remember to complete both sides of this form

Warren County Public Schools Health Services

Primary Care Provider Authorization: Seizure Monitoring (Side Two)

Student Name: ______________________________ Date of Birth: _________________________

School: ______________________ Grade: _______ School Year: _________________________

Please specify likely characteristics.						Recommended Interventions	Comments
Duration	Specify seconds, minutes, etc.						
Aura	Is there an Aura? ☐ Yes ☐ No Conditions or behaviors that usually precede the seizures:						
Extremities		Limp	Flexed	Extended	Jerking		
	Rt. Arm	☐	☐	☐	☐		
	Lt. Arm	☐	☐	☐	☐		
	Rt. Leg	☐	☐	☐	☐		
	Lt. Leg	☐	☐	☐	☐		
Eyes	Rolled Back			☐ Yes	☐ No		
	Twitching Back and Forth			☐ Yes	☐ No		
	Looking to Right			☐ Yes	☐ No		
	Looking to Left			☐ Yes	☐ No		
Mouth	Drawn to Right			☐ Yes	☐ No		
	Drawn to Left			☐ Yes	☐ No		
	Bites Tongue/Cheek			☐ Yes	☐ No		
	Teeth Clenched			☐ Yes	☐ No		
Breathing	Noisy/Loud Breathing			☐ Yes	☐ No		
	Shallow Breathing			☐ Yes	☐ No		
Other	Change in Skin Color			☐ Yes	☐ No		
	Drooling/Vomiting			☐ Yes	☐ No		
	Incontinent-Urine			☐ Yes	☐ No		
	Incontinent-Stool			☐ Yes	☐ No		

FORM MUST BE SIGNED BY HEALTH CARE PROVIDER AND PARENT/GUARDIAN

______________________ ______________________ ______________________

Printed MD, ARNP, or PA Address Date

______________________ ______________________ ______________________

Signature of MD, ARNP, or PA Telephone No. Fax No.

***Parent/guardian hereby acknowledges that if this medication will most likely be administered by a trained, unlicensed WCPS personnel. By signing this form, the parent/guardian acknowledges that the Warren County Board of Education, its employees and agents shall incur no liability as a result of any injury sustained by the student from any reaction to any medication to treat a seizure or the administration of such medication, unless the injury is the result of negligence or misconduct on behalf of the school or its employees.**

______________________ ______________________ ______________________

Signature of Parent/Guardian Telephone No. Date

______________________ ______________________ ______________________

Emergency Contact Telephone No. Relationship

Please remember to complete both sides of this form