Health Forms for Students with Seizures (Epilepsy)
Please complete packet and return to your child’s school nurse.

What is in this packet?

1) **STUDENT SEIZURE HISTORY** – for parent to describe student’s seizure history and list current medications.

2) **MEDICATION AUTHORIZATION FORM / GENERAL MEDICATION FORM**
   - Guidelines for Medications at School – on page 2 of Medication Authorization Form
   - Most oral seizure medications can be given at home before or after school, but if an oral seizure medication must be given at school, please complete this form
   - Must be signed by parent and Health Care Provider (HCP)
   - Signed form and medication should be brought to school by a responsible adult

3) **SEIZURE EMERGENCY ACTION PLAN**
   - Your Health Care Provider’s Seizure Action Plan form works or you may use the school’s Seizure Emergency Action Plan included in this packet.
     - Please include any current emergency seizure medications needed for school, i.e. nasal Versed (midazolam) or rectal Diastat (diazepam).
     - Please complete the Medication Authorization Form / General Medication Form (above) if an oral seizure medication cannot be given at home before or after school.

4) **VAGAL NERVE STIMULATOR (VNS) / DIASTAT® / VERSED MEDICATION/TREATMENT AUTHORIZATION FORM** - Please have this form completed and signed by your Health Care Provider if applicable; and return form to the school nurse each school year.

5) **AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION**

Questions? - Please call your school nurse
STUDENT SEIZURE HISTORY

Parent, please complete information below so your school nurse can provide care and create an Emergency Action Plan for your child, if needed. Please return this form to your school nurse.

CONTACT INFORMATION:
Student’s Name: ___________________________ Date of Birth: ____________ School Year: _________
School: __________________________________ Grade: ________________ Homeroom: ____________
Parent/Guardian Name: __________________________ Email: __________________________
Parent Guardian Tel: (H) _______________________(W) _______________________(C) _______________________
Neurologist: ___________________________________________ Tel: ______________________
Primary Care Doctor: ___________________________ Tel: ______________________
Significant medical history or conditions: __________________________________________

SEIZURE INFORMATION:
1. When was your child diagnosed with seizures or epilepsy? __________________________________________
2. Seizure Type(s)
<table>
<thead>
<tr>
<th>Seizure Type(s)</th>
<th>Length</th>
<th>Frequency</th>
<th>Description</th>
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</thead>
</table>
3. What might trigger a seizure in your child? __________________________________________
4. Are there any warnings and/or behavior changes before the seizure occurs? □ No □ Yes
   If YES, please explain: __________________________________________
5. When was your child’s last seizure? __________________________________________
6. Has there been any recent change in your child’s seizure patterns? □ No □ Yes
   If YES, please explain: __________________________________________
7. How does your child react after a seizure is over? __________________________________________
8. How do other illnesses affect your child’s seizure control? __________________________________________
9. Describe what constitutes an emergency for your child? (Answer may require consultation with treating physician and school nurse). __________________________________________
10. Has child ever been hospitalized for continuous seizures? □ No □ Yes
    If YES, please explain: __________________________________________

SEIZURE MEDICATION AND TREATMENT INFORMATION
11. What medication(s) does your child take? (Please include prescription emergency rescue medication- ie. Diastat, Versed)
    | Medication | Date Started | Dosage | Frequency and time of day taken |
    |------------|--------------|--------|--------------------------------|
12. What medication(s) will your child need to take during school hours? __________________________
13. Should any of these medications be administered in a special way? □ No □ Yes
    If YES, please explain: __________________________________________
14. Should any particular reaction be watched for? □ No □ Yes
    If YES, please explain: __________________________________________
15. Any special considerations & safety precautions for school activities: □ General health □ Gym/ sports (physical activity) □ Physical functioning □ Learning □ Field trips □ Recess □ Bus transportation □ Mood / coping □ Behavior □ Other Explain: ________________
16. Does your child have a Vagal Nerve Stimulator (VNS)? □ No □ Yes
    If YES, please describe instructions for appropriate magnet use or include physician’s orders: __________________________

I authorize Dayton Public Schools to communicate and share health information with appropriate school personnel to create an emergency action plan if necessary and to aid in present and future educational decisions.

Parent Signature: ___________________________ Date: ____________ Date Updated: ____________
Reviewed by School Nurse: ___________________________ Date: ____________
# Dayton Public Schools

## Health Services Department

Contact Information:

- Phone: 937-542-3346
- Email: [healthservices@dayton.k12.oh.us](mailto:healthservices@dayton.k12.oh.us)

## General Medication Form

### Student Information

<table>
<thead>
<tr>
<th>Student name</th>
<th>Date of birth</th>
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<thead>
<tr>
<th>School</th>
<th>Grade/Class</th>
<th>Teacher</th>
<th>School year</th>
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<tr>
<th>School Nurse</th>
<th>Phone</th>
<th>Fax</th>
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### Prescriber Authorization

<table>
<thead>
<tr>
<th>Name of medication</th>
<th>Diagnosis</th>
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<thead>
<tr>
<th>Dosage</th>
<th>Route</th>
<th>Time/Interval</th>
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<tr>
<th>Date to begin medication</th>
<th>Date to end medication</th>
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### Special Instructions

**Treatment in the event of an adverse reaction**

- **Epinephrine Auto-injector (self-carry)**
  - Not applicable
  - Yes, as the prescriber I have determined that this student is capable of possessing and using the auto-injector appropriately and has provided the student with training in the proper use of the auto-injector.

- **Asthma Inhaler (self-carry)**
  - Not applicable
  - Yes, if conditions are satisfied per O.R.C. 3317.716, the student may possess and use the inhaler at school or at any activity event or program sponsored by the school district in which the student’s school is a participant.

### Procedures for school employees if the student is unable to administer the medication or if it does not produce the expected relief:

- Possible Severe Adverse Reaction(s) per O.R.C. 3317.715 and 3317.716
  - a) To the student for whom it is prescribed (that should be reported to the prescriber)
  - b) To a student for whom it is not prescribed who receives a dose

<table>
<thead>
<tr>
<th>List any known drug allergies and reactions.</th>
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</table>

<table>
<thead>
<tr>
<th>Prescriber signature</th>
<th>Date</th>
<th>Phone</th>
<th>Fax</th>
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<td></td>
<td></td>
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<table>
<thead>
<tr>
<th>Prescription name (print)</th>
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**Reminder note for prescriber:** O.R.C. 3317.716 requires backup epinephrine auto-injector and best practice recommendations backup asthma inhaler.

### Parent/Guardian Authorization

- [ ] I authorize an employee of the school board to administer the above medication.
- [ ] I understand that additional parent/prescriber signed statements will be necessary if the dosage of medication is changed. I also authorize the school nurse for this student to confer with the licensed prescriber regarding my child’s health and treatment unless as they pertain to the medication(s) given and their attendance, educational, and behavioral management.
- [ ] Medication form must be received by the principal, nurse, doctor, and/or school nurse. I understand the medication must be in the original container and be properly labeled with the student's name, prescriber's name, date of prescription, name of medication, dosage, strength, time interval, route of administration and the date of drug expiration when appropriate.

<table>
<thead>
<tr>
<th>Parent/Guardian signature</th>
<th>Date</th>
<th>#1 contact phone</th>
<th>#2 contact phone</th>
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### Parent/Guardian Self-Carry Authorization

- [ ] For epinephrine auto-injector: As the parent/guardian of this student, I authorize my student to possess and use the epinephrine auto-injector, as prescribed, at school and any activity, event, or program sponsored or otherwise associated with the school’s activities, programs, or schools and activities. I understand that if a school employee or other person responsible for care and supervision fails to provide this medication, I will provide backup of the medication to the school principal or another responsible party.

- [ ] For an inhaler: As the parent/guardian of this student, I authorize my student to possess and use the inhaler as prescribed, at school and any activity, event, or program sponsored by or otherwise associated with the school’s activities, programs, or schools and activities. I understand that if a school employee or other person responsible for care and supervision fails to provide this medication, I will provide backup of the medication to the school principal or another responsible party.

<table>
<thead>
<tr>
<th>Parent/Guardian signature</th>
<th>Date</th>
<th>#1 contact phone</th>
<th>#2 contact phone</th>
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## Received by (school nurse):

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Guidelines for Medications at School

- DPS has one Medication Authorization form for all medications—oral, injectable, emergency (ex. Epinephrine Auto-Injector, asthma inhalers), and student self-carry medications.
- Any student needing to take medication during school hours must have a Medication Authorization form completed and signed by the parent and physician/prescribing healthcare provider.
- All medication must be in the container in which it was dispensed by the pharmacist or healthcare provider.
- The medication and Medication Authorization form must be brought together to the school by a parent or responsible adult.
- School personnel may not give over-the-counter medications unless prescribed by a healthcare provider. A Medication Authorization form must be completed and signed.
- No new medication can be given until the school nurse has reviewed it and checked it in.
- Routine injectable medication can only be given by a school nurse, parent (or parent-designated adult), or self-administered by the student.
- Changes in medication must be provided by the healthcare provider.
- Routine daily medication ordered three times a day or less may not need to be taken at school. The medication should be given before school, after school and at bedtime unless it is time-specific for during the school day. It is best for morning medication to be given at home.
- All medication orders must be renewed each school year.
- Parents are notified in writing to pick up all remaining medications at the end of the school year. Per DPS policy, any unused medications not claimed by the last day of school each year will be destroyed.
- Parents will be required to pick up all medications with the exception of inhalers and Epinephrine Auto-Injectors that the student already has written permission from their primary healthcare provider to carry on him/herself.
### Seizure Action Plan

**Effective Date**

This student is being treated for a seizure disorder. The information below should assist you if a seizure occurs during school hours.

<table>
<thead>
<tr>
<th>Student’s Name</th>
<th>Date of Birth</th>
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<tbody>
<tr>
<td>Parents/Guardian</td>
<td>Phone</td>
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<tr>
<td>Other Emergency Contact</td>
<td>Phone</td>
</tr>
<tr>
<td>Treating Physician</td>
<td>Phone</td>
</tr>
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</table>

**Seizure Information**

<table>
<thead>
<tr>
<th>Seizure Type</th>
<th>Length</th>
<th>Frequency</th>
<th>Description</th>
</tr>
</thead>
</table>

Seizure triggers or warning signs:  
Student’s response after a seizure:

#### Basic First Aid: Care & Comfort

Please describe basic first aid procedures:

- [ ] Yes  
- [ ] No

If YES, describe process for returning student to classroom:

#### Emergency Response

A "seizure emergency" for this student is defined as:

| Seizure Emergency Protocol  
<table>
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<tbody>
<tr>
<td>[ ] Contact school nurse at</td>
</tr>
<tr>
<td>[ ] Call 911 for transport to</td>
</tr>
<tr>
<td>[ ] Notify parent or emergency contact</td>
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<tr>
<td>[ ] Administer emergency medications as indicated below</td>
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<td>[ ] Notify doctor</td>
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<tr>
<td>[ ] Other</td>
</tr>
</tbody>
</table>

#### 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

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

#### Treatment Protocol During School Hours (Include daily and emergency medications)

|-------------|------------|---------------------------|------------------------------------------|

Does student have a Vagus Nerve Stimulator?  
- [ ] Yes  
- [ ] No

If YES, describe magnet use:

#### Special Considerations and Precautions (regarding school activities, sports, trips, etc.)

Describe any special considerations or precautions:

**Physician Signature**  
**Date**

**Parent/Guardian Signature**  
**Date**

Adapted for use for DFS, April 2020
Vagal Nerve Stimulator (VNS) / Diastat® / Versed
Medication/Treatment Authorization Form

Contact Information
Student’s Name: ___________________________ Date of Birth: __________ School Year:_____
School: ___________________________ Grade: ___________ Homeroom: ___________
Parent/Guardian Name: ___________________________ Email: ________________________
Parent Guardian Tel: (H) __________________ (W) ____________ (C) ____________
Neurologist: _________________________________________ Tel: ______________________
Primary Care Doctor: _____________________________ Tel: ______________________
Significant medical history or conditions: ____________________________

Diagnosis (include type of seizure): ____________________________

Medication/Treatment Order(s):
☐ Vagal Nerve Stimulator (VNS):
  ✓ Swipe VNS magnet at onset of seizure
  ✓ If seizure continues, swipe VNS every ____ seconds up to ____ times
  ✓ Additional orders: ____________________________

☐ Diastat® (diazepam) Rectal Gel
  ✓ Diastat® rectal gel _______ mg
  ✓ For seizure lasting more than ____ minutes. Give only ___ dose(s) in 24 hours.
  ✓ Additional orders: ____________________________

☐ Versed (midazolam) Nasal Spray
  ✓ Versed (Midazolam) nasal spray ____ mg
  ✓ For seizure lasting more than ____ minutes. Give only ____ dose(s) in 24 hours.
  ✓ Additional orders: ____________________________

☐ Call 911 if:
  ✓ Seizure does not stop by itself or with VNS swipe(s) within ____ minutes
  ✓ Child does not wake up within ____ minutes after a seizure has ended
  ✓ Anytime Diastat® or Versed is given (per Dayton Public School policy)
Administration to begin ______________________ Administration to end ______________________
List all other medication this child is taking: ____________________________
Severe adverse reaction to be reported to the physician: ____________________________
Please list any medication allergies: ____________________________
Special instructions: ____________________________
Name of Physician: _____________________________ Phone: _______________________
Address: _____________________________ Phone: _______________________
Physician’s Signature: _____________________________ Date: _______________________

Part II: TO BE COMPLETED BY PARENT OR GUARDIAN AND RETURNED TO SCHOOL
I request that the above medication be administered to my child according to the instructions provided. I agree to deliver the medicine to the school in the container in which it was dispensed by the prescribing physician or licensed pharmacist. I grant permission for the school nurse to confer with the above licensed prescriber regarding my child’s health and treatment issues as they pertain to the above medication/diagnosis and his/her educational and behavioral management needs. If the above information changes, I will submit a revised statement signed by the physician.

**Signature of Parent/Guardian: _____________________________ Date: __________
Address: _____________________________ Phone: _______________________
Home Phone: ______________________ Work Phone: ______________________ Cell Phone: ______________________

TO BE COMPLETED BY SCHOOL STAFF:
(Only the School Nurse or designated trained school staff will administer VNS/Diastat/Versed)
Person(s) Designated/Authorized for VNS/Diastat/Versed are: ____________________________

April 2020
Authorization for
Release of
Student Medical Information

Last name  First name  Middle
Address      City      State  Zip

Patient Information
Birthdate  Other possible names  Phone #

School Attending:  Grade:  Home Room:

Information Requested
Immunization record  Neurological
General / Medical  Surgical
Counseling Record  Orthopedic
Emergency / Urgent care record  Otorhinolaryngology (ENT)
Other:  Ophthalmology

Mail Copies
Fax copies

This information may be disclosed to and used by Dayton Public Schools. The following individual or organization is authorized to make the disclosure:

Mail to: School

School Representative  Title
Address                  Address

City  State  Zip  City  State  Zip

Phone#  Fax#  Phone#  Fax#

Action

Reason Needed
Continuity of Medical Care  Legal Reasons
At request of the Individual  Special Education
School Related  Other:

I hereby authorize Dayton Public Schools (DPS) to release and/or receive medical information, to/from the above party. This authorization may include release of information concerning treatment of drug or alcohol abuse, drug related conditions, Human Immunodeficiency Virus (HIV) test results, diagnosis or AIDS related conditions, alcoholism, and/or psychiatric/psychological conditions.

I understand that this authorization shall remain in effect for the school year 20____ - 20____, unless an earlier expiration date is specified in this space (_______). I also understand that I may withdraw this authorization at any time by written notification to the above parties involved. However, this written notification cannot effect actions that have taken place based on my prior authorization.

I understand that if the person or entity that receives the above information is not a healthcare provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.

Signature of Parent or Guardian  Date
Relationship to Student
Signature of School Representative  Date

Health Services 2/2004; Rev March 2020