CAMPBELL COUNTY SCHOOLS HEALTH SERVICES

Diana Taylor RN BSN
Campbell County Health Services Coordinator
Phone: (859)635-2173, ext: 1008

Dear Parent/Guardian

In preparation for the upcoming school year, it is important that we have accurate information/authorization to the special health-care needs of your child in the school setting.

Please have your child's physician complete the information on the appropriate forms prior to the beginning of the new school year. This information will be used to develop an Individualized Health Care Plan for your child in the school setting. Medications/procedures will not be administered until all forms are properly completed/signed by the parent and physician, and the parent/guardian provides medications and all supplies required.

All packets and medication forms are available on the Campbell County web page on the Health Services tab under "Departments". If your child has diabetes, Children's Hospital provides a school packet containing all information required for school attendance for those students managed through their clinic. Please contact them now and request that the packet be completed.

After July 25, please contact the nurse of the school your child will attend to set a time to meet with appropriate staff. If you have further questions, please contact me at: 859-635-2173, ext: 1008.

Thank you in advance for your cooperation. With your assistance we can insure a smooth transition for your child into the new school year.

Sincerely,

Diana Taylor RN

CAMPBELL COUNTY SCHOOLS HEALTH SERVICES

SEIZURE INDIVIDUALIZED HEALTH CARE PLAN

SCHOOL YEAR: _____

STUDENT INFORMATION			
STUDENT NAME:	DOB:		
GRADE/TEACHER:			
SCHOOL:	BUS#AM:	BUS#PM:	CAR RIDER: YES NO
STUDENT CONTACT INFORMATION			
PARENT/GUARDIAN:	PHONE:		WORK
PHONE:			
PARENT/GUARDIAN:	PHONE:		WORK
PHONE:			
EMERGENCY CONTACT:		PHONE:	
TREATING PHYSICIAN:		PHONE:	
SEIZURE INFORMATION			
TYPE OF SEIZURE:			
HOW DOES STUDENT PRESENT DURING SEIZURE:			
LENGTH OF TYPICAL SEIZURE:			
FREQUENCY OF SEIZURES:			
DATE OF LAST SEIZURE:			
EVENTS/TRIGGERS THAT MAY PRECIPITATE SEIZURE ACTIVITY:			
BEHAVIOR CHANGES/WARNING SIGNS OF IMPENDING SEIZURE:			
SPECIAL CONSIDERATIONS/PRECAUTIONS (SCHOOL ACTIVITIES/SPORTS/FIELD TRIPS/GYM, ETC.)			
VAGAL NERVE STIMULATOR			
VAGAL NERVE STIMULATOR: YES NO	LOCATION OF MAGNET:		
PARAMETERS FOR USE:			
EMERGENCY MEDICATIONS			
MEDICATION:	DOSAGE:		LOCATION:
AMINISTER AFTER _____MINUTES OF SEIZURE/CLUSTER ACTIVITY			
MEDICATION:	DOSAGE:		LOCATION:
ADMINISTER AFTER _____ MINUTES OF SEIZURE/CLUSTER ACTIVITY			
CONTACT PARENT IN THE FOLLOWING SITUATION(S):			

CAMPBELL COUNTY HEALTH SERVICES

SEIZURE INDIVIDUALIZED HEALTH CARE PLAN (CONT.)

STUDENT NAME:	**DOB:**

FIRST AID FOR ANY SEIZURE:

- **STAY** calm, keep calm, begin timing seizure
- Keep student **SAFE**- remove harmful objects, don't restrain, protect head
- **SIDE –** turn on side if not awake, keep airway clear, don't put objects in student's mouth
- **Notify** office/nurse/trained personnel
- **Administer** emergency treatment as ordered per physician per IHP if required. Contact EMS if emergency medication administered
- **STAY** with student until fully conscious or upon arrival of EMS

A SEIZURE IS CONSIDERED AN EMERGENCY/WHEN TO CALL 911

- Seizure with loss of consciousness lasting longer than 5 minutes, not responding to rescue meds if available
- Repeated seizures with no recovery between them, not responding to rescue med if available
- Difficulty breathing during and after seizure
- Student is injured, pregnant, or has diabetes
- First time seizure
- Seizure in water

SIGNATURE

As parent/guardian of the above-named student, I give permission for my child's healthcare provider to share information wit the school nurse for the completion of this plan of care. I understand the information contained in this plan will be shared with school staff on a need-to-know basis. It is the responsibility of the parent/guardian to notify the school nurse of any change in the student's health status, care, or medication order. If medication is ordered, I authorize school staff to administer medication to my child per physician order. If prescription is changed, a new CCS Consent to Administer Medication Form must be completed & signed by the physician & parent before the school staff can administer the medication. Parents/Guardians are responsible for maintaining necessary supplies, medications, and equipment.

PARENT SIGNATURE:	**DATE:**
PHYSICIAN SIGNATURE:	**DATE:**

SCHOOL NURSE

SEIZURE EMERGENCY INDIVIDUALIZED HEALTH CARE PLAN distributed to "need to know" staff:

___Front Office/Admin ____Teachers ___ Transportation ____ Other (specify):

School Nurse Signature:	**Date:**

CAMPBELL COUNTY SCHOOLS HEALTH SERVICES

Consent for Administration of Medication at School

Student Name: _____ Grade: ____ Teacher: _____

School: _____

Name of Medication: _____

Dosage: _____ Time(s) of administration: _____ _____ _____

As Needed (PRN): Indicators for use: _____

Route of Administration: _____

Diagnosis or Reason for Medication to be Administered: _____

Possible Side-Effects: _____

Student Allergies: _____

Physician Authorization

Physician Name: _____ Phone: _____

Physician Signature: _____ Date: _____

Parent Guardian Authorization

I authorize an employee of the school to administer the above medication. I understand that additional parent/prescriber signed statements will be necessary if the dosage/times of medication is changed. I also authorize the licensed healthcare professional to talk with the prescriber or pharmacist to clarify the medication order.
I understand that 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 expiration date of medication.
I waiver any liability on behalf of the school as a result of administration of the above medication.

Parent/Guardian Signature: _____ Date: _____

Parent/ Guardian Phone: _____

Contact #2 Name: _____ Phone: _____

AGREEMENT FOR THE ADMINISTRATION OF EMERGENCY CARE

The undersigned parent/guardian of _____
a pupil in the Campbell County Public Schools, has advised the Board of Education of Campbell County that his/her child named above suffers from a medical condition which may be life threatening unless immediate emergency care is provided in a crisis which may arise from the child's health problem.

Accordingly, the Board of Education of Campbell County has adopted a procedure wherein a member of the staff of the school the child is attending will administer either an injection or prescribed drug in the event of a crisis. The undersigned understands that the staff member administering the above care is not a trained health professional, but that this individual will undertake to do his or her best to comply with the recommended procedure as developed by the child's physician in the case of a life-threatening emergency wherein immediate intervention is required by the volunteer.

The undersigned parent/guardian does hereby consent to the intervention of the volunteer staff member in accordance with the instructions contained in the attached letter from the child's physician. Additionally, the undersigned agrees to hold that volunteer harmless for any injuries resulting from the emergency care unless the injury was caused by the volunteer's negligence.

Dated at Alexandria, Kentucky, this the _____ day of _____. _____
(Day) (Month) (Year)

X _____
(Parent/Guardian Signature)