Seizure Questionnaire – **TO BE COMPLETED BY PARENT(S)**

Student's name:_____ Program:_____

At what age was your student diagnosed with seizures?_____

Please list the type of seizures your student is affected by:_____

When was your student's most recent seizure?_____

Does your student take medications to control seizures? **YES** **NO**

If so, please list the medication and dose below. Please include any rescue medications that your provider has prescribed.

_____

_____

Will your student need to keep/take medication at school? (This includes rescue medications.) **YES** **NO**
If yes, please complete the attached Medication Authorization Form and provide medications to the clinic ASAP!

Does your student have a Vagus Nerve Stimulator? **YES** **NO**

What might trigger a seizure?_____

_____

Are there any warning signs and/or behavior changes before the seizure occurs? **YES** **NO**

If yes, please explain:_____

_____

When possible, would you like your student be pulled from the classroom prior to fire drills? **YES** **NO**

Please include any additional information you would like us to be aware of pertaining to your student's medical condition(s).

_____

_____

_____

I consent to the release of information contained in my student's Seizure Management Plan to all school staff members and other adults who have responsibility for my child and who may need to know this information to maintain my child's health and safety. I also give permission to the School Nurse to communicate with my child's physician/healthcare provider relating to seizure management.

Parent signature/Date:_____

School Nurse signature/Date:_____

My Seizure Response Plan

EPILEPSY FOUNDATION

Name: _____ Birth Date: _____

Address: _____ Phone: _____

1st Emergency Contact /Relation: _____ Phone: _____

2nd Emergency Contact / Relation: _____ Phone: _____

Seizure Information

Seizure Type/Nickname	What Happens	How Long It Lasts	How Often

Triggers

_____

_____

Daily Seizure Medicine

Medicine Name	Total Daily Amount	Amount of Tab/Liquid	How Taken (time of each dose and how much)

Other Seizure Treatments

Device Type: _____ Model: _____ Serial# _____ Date Implanted _____

Dietary Therapy: _____ Date Begun: _____

Special Instructions: _____

_____

Other Therapy: _____

_____

continued on back

Seizure First Aid

- ☐ Keep calm, provide reassurance, remove bystanders
- ☐ Keep airway clear, turn on side if possible, nothing in mouth
- ☐ Keep safe, remove objects, do not restrain
- ☐ Time, observe, record what happens
- ☐ Stay with person until recovered from seizure
- ☐ Other care needed: _____

Call 911 if...

- ☐ Generalized seizure longer than 5 minutes
- ☐ Two or more seizures without recovering between seizures
- ☐ "As needed" treatments don't work
- ☐ Injury occurs or is suspected, or seizure occurs in water
- ☐ Breathing, heart rate or behavior doesn't return to normal
- ☐ Unexplained fever or pain, hours or few days after a seizure
- ☐ Other care needed: _____

When Seizures Require Additional Help

Type of Emergency (long, clusters or repeated events)	Description	What to Do

"As Needed" Treatments (VNS magnet, medicines)

Name	Amount to Give	When to Give	How to Give

Health Care Contact

Epilepsy Doctor: _____ Phone: _____

Nurse/Other Health Care Provider: _____ Phone: _____

Preferred Hospital: _____ Phone: _____

Primary Care: _____ Phone: _____

Pharmacy: _____ Phone: _____

Special Instructions: _____

_____

My signature _____ Date _____

Provider signature _____ Date _____

EPILEPSY FOUNDATION

***Please be advised of the following medication policies**

Medication authorization forms can be obtained in the school clinic located within the high school office. The forms are also available for download on our website at:

http://www.mcjvs.edu/ui/Current_Students/Student_Services-2

Prescription Medications: Students needing prescription medication must have signed authorization from both a parent and their physician. The clinic can assist in obtaining theses signatures via fax **unless** they are narcotic/controlled substances (see following policy). **ALL** prescription medication must be in the original pharmacy container that includes proper labeling. If there is a need for the medication to be given at home as well as at school, upon request, pharmacies are happy to supply you with an additional properly labeled container. **Students will not be permitted to carry medications back and forth to school on a daily basis.**

Narcotic Pain Medications/Controlled Substances: Parent's must obtain written physician authorization to use these types of medications during school hours. Orders for controlled substances will only be valid for ten school days. If the student's needs extend beyond the initial ten day authorization, parents are required to contact their doctor for a renewed order. Students using narcotic pain medications are strongly encouraged to provide an over-the-counter pain alternative. Again, be advised, **students will not be permitted to carry medications back and forth to school on a daily basis.**

Over-the-counter (OTC) medications: Students needing to take OTC medications during school must provide written parental authorization before doing so. Telephone requests or written notes for administration will not be honored. Students must provide their own supply of non-expired OTC medications in the original container. The clinic will **NOT** supply or distribute any medication unless it is supplied by the student/parent. This includes Tylenol, Motrin, Benadryl, Neosporin and even cough drops...**NO EXCEPTIONS!!!**

Epi Pens & Inhalers: Students required to carry Epi Pens and/or inhalers due to a medical condition may do so with proper documentation on file. Students in need of such medications must meet with the School Nurse to ensure a safety plan is in place. **Ohio law mandates that students who self-carry their Epi pens MUST provide a back-up dose to the clinic.**

If you have questions/concerns not covered in the above policy, please feel free to contact the School Nurse, Melonie Queberg, RN at 330-725-8461, ext. 344.

Melonie Queberg RN, BSN

MEDINA COUNTY CAREER CENTER

Authorization for the Administration of Prescription Medication By School Personnel

Since medication for the student listed below cannot be scheduled for other than school hours and the administration of such medication may be supervised by medically untrained personnel, it is requested that the oral medication as indicated below be administered by school personnel.

Student Name _____ Date of Birth _____

School _____ Grade _____ Program _____

PARENT/ GUARDIAN SECTION

Please review the following steps required for permission of school personnel to administer any medication to your child and sign this section:

1. Both the parent (top section) and the licensed prescriber (bottom section) must complete this form.
2. Medication must be provided in the student's labeled prescription bottle. (The pharmacy may provide an extra bottle for long-term medication.) The prescription label must match the instructions from the prescriber. If it is a non-prescription medication, it must be in the original container.
3. I release and agree to hold the Board of Education, its officials, and its employees harmless from any and all liability ***foreseeable or unforeseeable*** for damages or injury resulting directly or indirectly from this authorization.
4. New forms must be submitted when there is a change in the original forms. (I.e. dose, time)

I request that medication be administered to my son/daughter according to the directions of the licensed prescriber in the following section. I also authorize the exchange of information between the health care provider and the school regarding this medication order when deemed necessary by school personnel.

Signature of Parent _____ Date _____

Daytime Phone _____

LICENSED PRESCRIBER SECTION

I verify that this medication must be taken by: _____
Name of Student

Diagnosis (reason) for which medication is prescribed _____

Medication _____ Strength _____ Dose _____

Time medication is to be taken _____ Administration start date _____ Cease Date _____

Instructions or precautions, including possible side effects & storage _____

Licensed prescriber signature _____ Date _____

Licensed prescriber printed name _____ Phone _____

Student to self- carry and self-administer Epi-Pen _____ Date _____ Physician Initials _____

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