FLORIDA DEPARTMENT OF HEALTH

Homer Rice
Administrator

LEON COUNTY SCHOOLS

Jackie Pons
Superintendent

Dear Parent/Guardian,

Your child has been identified as having a seizure disorder which may require medical management during the 2012-2013 school year. Enclosed are important documents that need to be **completed by you and the health care provider who is managing your child's seizure disorder**. These documents provide a guide for your child's care during the school day. The Registered Nurse assigned to your child's school will provide training to designated school personnel based on this information.

The following forms need to be completed and returned to the school health room as soon as possible:

- Seizure Management Plan (to be completed **and** signed by your child's health care provider).
- Consent for Sharing of medical Information (check off each applicable agency **and** add other provider if not listed)
- Medication Permission Form (completed for each medication taken at school)

Students who require **Diastat** for emergency treatment must have the following additional forms:

- Physician's Order for Diastat (to be completed **and** signed by the prescribing doctor)
- Specialized Health Care Procedure Authorization Form for Diastat (to be completed **and** signed by prescribing physician)

Remember to keep copies of these documents for your records!

If you have any questions, please call Leon County Health Department School Health Division at 606-8150.

Sincerely,

Nancy Cooper, RN, BSN, NCSN

Nancy Cooper, RN, BSN, NCSN
School Health Coordinator
Leon County Health Department

Leon County Seizure Action Plan for the 20_____-20_____School Year

This student is being treated for a seizure disorder. The information provided below is intended to assist school personnel should a seizure occur during school hours.

The Following is to be Completed by the Parent

Student's Name_____ DOB_____ Age_____

Allergies_____ Significant Medical History_____

Date of last seizure_____ How long does a typical seizure last?_____

How often do seizures occur?_____

Treating Physician_____ Phone_____ Fax_____

School_____ Grade_____ HR Teacher_____

Parent/Guardian_____ Phone_____ _____

Parent/Guardian_____ Phone_____ _____

The Following is to be Completed by the Medical Provider

Date of seizure diagnosis _____

Medical Diagnosis_____

Current medication(s)_____

_____

Special considerations or safety precautions_____

Student Specific Seizure Emergency Plan Per Medical Provider

Call 911 and parent/guardian for seizure activity in this student

☐ Absence (petit mal) seizure lasting longer than_____ minutes

☐ Generalized Tonic Clonic (grand mal) seizure lasting longer than_____ minutes

☐ Cluster seizure activity _____ or more seizures in_____ hour

☐ Other seizure (indicate type)_____ lasting longer than _____ minutes

☐ Administer Diastat (write order here)_____

_____

Other considerations for student with seizure emergency at school:

√Complete Seizure Observation Form
(Send with EMS if possible)

√Notify School Nurse (RN)

Basic Seizure First Aid

- Stay calm & note time seizure began
- Keep student safe
- Do not put anything in student's mouth
- Do not restrain
- Protect head
- Stay with student & watch breathing

Physician Signature_____ Date_____

Parent Signature_____ Date_____

School Nurse Signature_____ Date_____

5/12

Child Specific Training Log

School Year: _____

Student Name: _____ School: _____

Type of Training: _____

Date	Name/Title	RN Signature

LEON COUNTY HEALTH DEPARTMENT

CONSENT FOR SHARING OF PROTECTED HEALTH INFORMATION

School Year_____

Student's Name: _____
DOB: _____
School: _____

I hereby consent to health information being shared to carry out treatment or clarify medical orders in order to keep my child safe while at school. I understand that Registered Nurses from Leon County Health Department, School Health Division, may be giving and receiving information pertaining to the management of my child's medical condition with the following organizations:

(Please check *and* initial all that apply)

___ [X] Leon County School District
___ [ ] Tallahassee Memorial Hospital Diabetes Center
___ [ ] Children's Medical Services
(Name of case manager: _____)
___ [X] Leon County Health Department
___ [ ] Tallahassee Pediatric Foundation

___ [ ] Primary Physician_____
(Please fill in Physician name)
___ [ ] Specialist Physician_____
(Please fill in Physician name)

I may request a notice of the complete description of such uses and disclosures prior to signing this consent.

I understand that I have the right to revoke this consent in writing.

_____
Signature of Parent/Guardian or eligible student

_____
Date

Revised 5/12

Specialized Health Care Procedure:

Administration of Diastat

Definition/Purpose: Epilepsy is a neurological condition that makes people susceptible to seizures. A seizure is a change in sensation, awareness, or behavior brought about by a brief electrical disturbance in the brain. **Diastat** (DI-a-STAT) is a formulation of diazepam specifically designed for rectal administration to control prolonged seizures and bouts of increased seizure activity (clusters).

Requirements: Parents/guardians are required to sign a written authorization for the Administration of Diastat. Parents/guardians are also required to complete a Medication School Permission Form. A physician's (written and signed) order must also be obtained (Physician's Order for Diastat).

Personnel Authorized to Perform Procedure: Can be performed by an RN or LPN, or by any designated staff member trained by the nurse. Training will be reviewed on a yearly basis.

Equipment Needed: Gloves, Diastat kit from locked cabinet, blanket (for privacy), and pillow to place under student's head (if possible)

Classroom Duties:
Seizure Activity Begins:

1. Call out time Seizure Activity begins.
2. ID person responsible for completion of Seizure Monitoring Form.
3. ID person responsible for caring for student with seizure activity.
4. ID person responsible for other students' care.
5. ID person responsible for initiating emergency measures if seizure lasting longer than time indicated on Physician's Order for Diastat.

If generalized tonic clonic (Grand Mal), Absence (Petit Mal) seizure or other seizure (indicated by physician) lasts longer than time indicated on Physician's Order for Diastat:

1. Dial 911 identify school, student name, age, and condition and that **Diastat** is being administered **rectally**.
2. Administer Diastat rectally.
3. Monitor respirations, may need to provide rescue breathing.
4. Call Office to notify of EMS activation.

Administering Diastat
Gather supplies (listed above). Check medication for:

- Right student
- Right medication
- Right route (rectal)
- Right dose (See Physician's Order for Diastat)
- Right time (See Physician's Order for Diastat)

Procedure:

1. Put person on their side where he or she cannot fall.
2. Get medicine (Diastat kit). (Do not leave student unattended.)
3. Put on gloves.
4. Get syringe from kit. Push up with thumb and pull to remove protective cover from syringe.
5. Lubricate rectal tip with lubricating jelly.
6. Turn person on side facing you.
7. Bend upper leg forward to expose rectum.
8. Separate buttocks to expose rectum.
9. Gently insert syringe tip into rectum.
10. Slowly count to 3 while gently pushing plunger in until it stops.
11. Slowly count to 3 before removing syringe from rectum.
12. Slowly count to 3 while holding buttocks together to prevent leakage.
13. Keep person on side facing you, note time given, and continue to observe.

Office duties:

1. Have an employee wait outside for ambulance and provide directions to student's location (may be identified by office staff).
2. Notify parent/guardian.

When EMS arrives:

1. Turn over care to EMS.
2. Provide all Emergency Medical information to EMS personnel **(COPIES, NOT ORIGINALS)**:
   - Emergency and Medical information Card
   - Physician's order for Diastat
   - Parent/Physician Authorization Form for Specialized Health Care Procedure (for Diastat)
   - Seizure Monitoring Form, if possible
3. Give used Diastat syringe and package with prescription label to EMS personnel (or dispose of properly).
4. Complete Accident Report.

Parent and Physician: Please complete attached page.

Parent Authorization for Specialized Health Care Procedure

I, the undersigned, who is the parent/guardian of _____ request that the following health care service:

Administration of Diastat

be administered to my child. I understand that a trained designated staff member will be performing this procedure. It is my understanding that in performing this procedure, the designated person(s) will be using a standardized procedure which has been approved by our physician. I will notify the school immediately if the health status of our child changes, I change physicians, or there is a change or cancellation of the procedure.

Signature of parent/guardian _____

Date _____

Physician's Order for Specialized Health Care Procedure

Student's Name _____ DOB _____

Procedure: **Administration of Diastat**

Check one:

_____ I have reviewed the Health Care Procedure and approve of it as written.

_____ I have reviewed the Health Care Procedure and approve of it with the attached amendments.

_____ I do not approve of the Health Care Procedure. A substitute procedure is attached.

Duration of the procedure (not to exceed current school year): _____

Physician's Signature: _____ **Date:** _____