Bracken County School Health Program

Emergency Action Plan

Dear Parent/Guardian,

You have identified your child as having a **life threatening condition** that may require emergency treatment or medications to be given at school. Please complete the "Emergency Action Plan" for your child who may need emergency treatment for diabetes, asthma, severe allergies, seizures, or other serious medical conditions and return it to school.

Please contact the school health office if you need help completing the form.

Emergency situations may arise and it is important to have the needed information to care for your child.

There MUST be a written order, from your child's doctor, on file at the school for all prescription medications. There is an additional form that must be completed if you want your child to carry the emergency medication (i.e., inhaler, Epi-pen, Diastat, Glucagon,etc). Please contact the school nurse for any further questions.

Thank you,

Bracken County School Nurse

Permission Form for Prescribed Medication

TO BE COMPLETED BY SCHOOL PERSONNEL

School: _____ Date form received: _____

I/we acknowledge receipt of this Physician's Statement and Parent Authorization. _____

Student Name: _____ Student age: _____ Date of Birth: _____

Grade: _____ Homeroom/Classroom: _____

TO BE COMPLETED BY PHYSICIAN OR AUTHORIZED PROVIDER

Name of medication: _____

Reason for medication: _____

Form of medication/treatment:

☐ Tablet/capsule ☐ Liquid ☐ Inhaler ☐ Injection ☐ Nebulizer ☐ Other _____

Instructions (Schedule and dose to be given at school): _____

_____

Start: ☐ Date form received ☐ Other, as specified: _____

Stop: ☐ End of school year ☐ Other date/duration: _____

For episodic/emergency events only

Restrictions and/or important side effects: ☐ No restriction

☐ Yes. Please describe: _____

_____

Special storage requirements: ☐ None ☐ Refrigerate

Other: _____

Physician's Signature _____ Physician's Name: _____

Date _____ Phone _____ Address: _____

For Self-Administration ONLY For Self-Administration ONLY For Self-Administration ONLY For Self-Administration ONLY

This student has been trained on self-administration of this medication: to be completed for asthmatic, diabetic or severe allergy ONLY

☐ No ☐ Supervision required ☐ Supervision not required

This student may carry this medication: ☐ No ☐ Yes

Please indicate if you have provided additional information

☐ On the back: side of this form ☐ As an attachment

Signature: _____ Date _____

Physician or Authorized Provider

TO BE COMPLETED BY PARENT / GUARDIAN

I give permission for (name of child) _____ is to receive the above stated medication at school according to standard school policy. I release the Bracken County School Board and its employees from any claims or liability connected with its reliance on this permission. (Parent/guardians to bring the medication in its original container.)

Date: _____ Signature: _____ Relationship: _____

Home phone: _____ Work phone: _____ Emergency phone: _____

BRACKEN COUNTY SCHOOL DISTRICT

SEIZURE INDIVIDUAL HEALTH PLAN

Name:	Date:	Student Picture
Birth Date:	Student # :	
School:	Grade:	
SEIZURE MANAGEMENT PLAN:		

Possible triggers, and student's warning signs:
(Behavior changes prior to seizure?)

Typical Seizure Pattern, student's seizures usually look like:

(Describe seizure, time of day, length of seizure, student's reaction to seizure)

During a Seizure:

- Always stay with the child.
- Position child to avoid choking on saliva.
- Protect the child from injury. If possible move student to the floor.
- Move furniture and objects out of the way.
- Do not restrain child or put anything in their mouth.
- Place something flat and soft under the student's head.
- If student vomits during the seizure, turn student onto their side.
- Loosen any tight clothing and remove glasses if applicable.
- Someone remain with child until conscious and no longer confused.
- CPR should NOT be given during a seizure

CALL 911 FOR:

- A seizure lasting longer than _____ minutes
- Any signs of respiratory distress (stops breathing or turns dusky/blue)
- Other:

Please mark area below:

_____I want my child's Diastat to be transported with my child.

_____I want my child's Diastat to be left at school.

After a Seizure:
• Call parent ( ) at _____ • Allow child to rest. • Reassure the student and gently help to re-orient as consciousness returns. Student may feel drowsy and disoriented. • Document the seizure, making note in 3 areas – what happened before, during and after the seizure. Note how long the seizure lasted. • If other students are present during a seizure, they will also need reassurance, and perhaps a short time to talk about what happened. Be sure to share any news about their classmate that would be supportive and reassuring. • Student may want to go home following a seizure.
Other health concerns:

Medications:	**Dose/Time:**

Parent Signature	**Date:**

Dietary concerns/restrictions:

EMERGENCY CONTACTS	
Parent/Guardian: 1. 2 e-mail:	**Home phone:** Work: Cell: Work: Cell:
Emergency contact:	**Phone:**
Primary Care Physician:	**Phone:** **Fax:**
Specialty MD:	**Phone:** **Fax:**
School Nurse: **Email:**	**Phone:** **Fax:**

Copies:

- ☐ Parent
- ☐ Teacher
- ☐ Library
- ☐ Transportation
- ☐ Food Services
- ☐ Health Room

1st___ 2nd___ 3rd___ 4th___ 5th___ 6th___ 7th___