QUESTIONNAIRE FOR PARENT OF A STUDENT WITH SEIZURES

Please complete all questions. This information is essential for the school nurse and school staff in determining your student's special needs and providing a positive and supportive learning environment. If you have any questions about how to complete this form, please contact your child's school nurse.

CONTACT INFORMATION:

Student's Name:_____ School Year:_____ Date of Birth:_____
School:_____ Grade:_____ Classroom:_____
Parent/Guardian Name:_____ Tel. (H):_____ (W):_____ (C):_____
Other Emergency Contact:_____ Tel. (H):_____ (W):_____ (C):_____
Child's Neurologist:_____ Tel:_____ Location:_____
Child's Primary Care Dr.:_____ Tel:_____ Location:_____
Significant medical history or conditions:

SEIZURE INFORMATION:

1. When was your child diagnosed with seizures or epilepsy?_____
2. Seizure type(s):

Seizure Type	*Length*	*Frequency*	*Description*

3. What might trigger a seizure in your child?_____
4. Are there any warnings and/or behavior changes before the seizure occurs? YES NO
   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? YES NO
   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?_____

BASIC FIRST AID: Care and Comfort Measures

9. What basic first aid procedures should be taken when your child has a seizure in school?_____

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 (grand mal) seizure:
- ✓ Protect head
- ✓ Keep airway open/watch breathing
- ✓ Turn child on side

10. Will your child need to leave the classroom after a seizure? YES NO
    If YES, What process would you recommend for returning your child to classroom:_____

SEIZURE EMERGENCIES

11. Please describe what constitutes an emergency for your child? (Answer may require consultation with treating physician and school nurse.)_____

_____

_____

_____

_____

12. Has child ever been hospitalized for continuous seizures? YES NO
    If YES, please explain: _____

_____

A Seizure is generally considered an Emergency when:

- ✓ A convulsive (tonic-clonic) seizure lasts longer than 5 minutes
- ✓ Student has repeated seizures without regaining consciousness
- ✓ Student has a first time seizure
- ✓ Student is injured or diabetic
- ✓ Student has breathing difficulties
- ✓ Student has a seizure in water

SEIZURE MEDICATION AND TREATMENT INFORMATION

13. What medication(s) does your child take?

Medication	Date Started	Dosage	Frequency and time of day taken	Possible side effects

14. What emergency/rescue medications needed medications are prescribed for your child?

Medication	Dosage	Administration Instructions (timing* & method**)	What to do after administration:

* *After 2nd or 3rd seizure, for cluster of seizure, etc.* ** *Orally, under tongue, rectally, etc.*

15. What medication(s) will your child need to take during school hours?_____
16. Should any of these medications be administered in a special way? YES NO
    If YES, please explain:_____
17. Should any particular reaction be watched for? YES NO
    If YES, please explain:_____
18. What should be done when your child misses a dose?_____
19. Should the school have backup medication available to give your child for missed dose? YES NO
20. Do you wish to be called before backup medication is given for a missed dose?
21. Does your child have a Vagus Nerve Stimulator? YES NO
    If YES, please describe instructions for appropriate magnet use:_____

_____

SPECIAL CONSIDERATIONS & PRECAUTIONS

22. Check all that apply and describe any considerations or precautions that should be taken

- ❑ General health_____
- ❑ Physical functioning_____
- ❑ Learning:_____
- ❑ Behavior:_____
- ❑ Mood/coping:_____
- ❑ Physical education (gym)/sports:_____
- ❑ Recess:_____
- ❑ Field trips:_____
- ❑ Bus transportation:_____

Other:_____

GENERAL COMMUNICATION ISSUES

23. What is the best way for us to communicate with you about your child's seizure(s)?_____

_____

24. Can this information be shared with classroom teacher(s) and other appropriate school personnel? YES NO

Parent/Guardian Signature:_____ Date:_____ Dates Updated:_____, _____

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.

Student's Name:_____ Date of Birth:_____

Parent/Guardian:_____ Phone: _____Cell:_____

Treating Physician:_____ Phone: _____

Significant medical history:_____

SEIZURE INFORMATION:

Seizure Type	*Length*	*Frequency*	*Description*

Seizure triggers or warning signs:_____

Student's reaction to seizure:_____

BASIC FIRST AID: CARE & COMFORT: *(Please describe basic first aid procedures)*

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 (grand mal) seizure:
- ✓ Protect head
- ✓ Keep airway open/watch breathing
- ✓ Turn child on side

Does student need to leave the classroom after a seizure? YES NO

If YES, describe process for returning student to classroom

EMERGENCY RESPONSE:

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

A Seizure is generally considered an Emergency when:
- ✓ A convulsive (tonic-clonic) seizure lasts longer than 5 minutes
- ✓ Student has repeated seizures without regaining consciousness
- ✓ Student has a first time seizure
- ✓ Student is injured or has diabetes
- ✓ Student has breathing difficulties
- ✓ Student has a seizure in water

Seizure Emergency Protocol: *(Check all that apply and clarify below)*

☐ Contact school nurse at _____

☐ Call 911 for transport to _____

☐ Notify parent or emergency contact

☐ Notify doctor

☐ Administer emergency medications as indicated below

☐ Other_____

TREATMENT PROTOCOL DURING SCHOOL HOURS: (include daily and emergency medications)

Daily Medication	Dosage & Time of Day Given	Common Side Effects & Special Instructions

Emergency/Rescue Medication

Does student have a **Vagus Nerve Stimulator (VNS)**? YES NO

If YES, Describe magnet use_____

SPECIAL CONSIDERATIONS & SAFETY PRECAUTIONS: *(regarding school activities, sports, trips, etc.)*

Physician Signature:_____ **Date:**_____

Parent Signature:_____ **Date:**_____

KLEIN ISD
FUTURE READY
www.kleinisd.net

Procedure for Administration of Diazepam Rectal Gel (Diastat)

PURPOSE:
To assure the safe and timely administration of Diazepam Rectal Gel (Diastat) if it should become necessary during the time the child is at school. Diazepam Rectal Gel (Diastat) is an emergency intervention drug used in controlling or stopping status epilepticus or other seizures. This medication is given as ordered by the physician and can be administered only by the registered professional school nurse or the school nurse's delegate.

EQUIPMENT:
Completed Klein ISD Diazepam Rectal Gel (Diastat) orders signed by the physician.
Written parental permission.
Properly labeled pharmaceutical container with unexpired medication.
Copy of procedure with diagrams.

PROCEDURE:
1. Keep calm – let seizure run its course.
2. **DO NOT** attempt to restrain student or force object between teeth.
3. Ease child to floor if possible and remove objects which may cause injury.
4. Turn on side to prevent aspirating saliva.
5. Loosen tight clothing and place something soft and flat under head.
6. Time seizure and observe seizure pattern.
7. Have student's care plan and emergency care plan in place.
8. Administer Diazepam Rectal Gel (Diastat) according to attached order.
9. Call 911 unless otherwise directed by physician.
10. **Call 911 for the initial dose of Diazepam Rectal Gel (Diastat.)**
11. Call parent or guardian to take child home from school after administration of Diazepam Rectal Gel (Diastat) if physician has indicated that it is not necessary to call 911. The child should be closely observed for breathing, color, and other possible side effects of treatment for 4 hours.
12. Allow child to rest and observe closely until emergency personnel or parent/guardian arrives to take child home. **Do not leave child unattended.**
13. Document Diazepam Rectal Gel (Diastat) on medication log both front and reverse and complete comprehensive nurse's note in computer.

KLEIN ISD
FUTURE READY
www.kleinisd.net

DIAZEPAM RECTAL GEL (DIASTAT) ORDERS

Student's Name: _____
Last First

DOB: _____ Grade: _____ ID#: _____

School Year:_____

Procedure for Administration of Diazepam Rectal Gel (Diastat):

1. Diazepam Rectal Gel (Diastat) Dosage: _____
2. Indications for treatment (be very specific) including length of time seizure(s) should last before treatment begins:

   _____
3. Side effects expected after the administration of medication:_____
4. Action to be taken if child has bowel movement or expels medication: _____

   _____
5. Should medication be given if child has fever, respiratory infection or cold: _____
6. Protocol is to call 911 after administering Diazepam Rectal Gel (Diastat) unless specifically ordered otherwise (*and always after initial dose of this drug*). Please explain in detail any circumstances where it is not necessary to call 911:

   _____

   _____

   _____
7. ***Please note: if prolonged seizure occurs at any time when a school nurse (RN) is not available, 911 will be called.***

Printed name of physician: _____

Physician's signature: _____

Physician's phone number: _____ Fax: _____

Date: _____

I request that Diazepam Rectal Gel (Diastat) be administered to my child according to the signed protocol from my physician.

I hereby give my permission for the school nurse to consult with the prescribing physician regarding the above orders.

Parent/Guardian Signature _____ Date: _____

Emergency phone numbers: _____

KLEIN INDEPENDENT SCHOOL DISTRICT
MEDICATION AUTHORIZATION FORM

STUDENT:_____ DATE OF BIRTH:_____

In an effort to promote student health and maintain school performance, it is necessary that medication be given during school hours.

Physician's request for giving medication(s) during school hours:

NAME OF MEDICATION	DAILY DOSAGE	SCHOOL DOSAGE	TIME TO BE GIVEN
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____

Comments: (Reason for medication, possible side effects, etc.)

_____

_____

*No injections may be given except those needed in emergency situations or those necessary for the student to remain in school (i.e. insulin, epinephrine).

Physician's Signature: _____ Date: _____

Physician's Name (**Please Print**): _____Phone: _____

****

Klein school personnel are not permitted to give medication of any kind, including aspirin, similar preparations, or any other drugs, unless the parent requests in writing that there is a need for such medication. Non-prescription medications needed for longer than two weeks must also have a written request from a physician. When administering prescription medicines, the school district would prefer to have a written statement from a physician or dentist licensed to practice in the United States. Information, however, placed on a prescription label, if it is precise and clear to the school nurse, may be substituted for the above noted statement. The prescription must be filled by a pharmacist licensed to practice in the United States. All medications must be in their original container and kept in locked storage in the office of the nurse or principal's designee and administered by the nursing staff or a school employee. If the circumstances are questionable, the school employee reserves the right to deny the parent's request. No vitamins, health food or herbal preparations will be given by any school employee. Neither prescriptions nor over the counter medications from foreign countries will be administered.

****

PARENT/GUARDIAN AUTHORIZATION

I hereby authorize school personnel to administer non-prescription medication to my child during school hours or prescription medication as prescribed by the physician. I understand that any non-prescription medication that is to be dispensed to my child longer than two weeks will also need a doctor's authorization. Also, I am aware that no medication dosage will be changed without an order from the prescribing physician.

*I **(do / do not)** authorize school personnel, at my oral request, to administer dosages of medication in addition to the dosages specified on this form, if necessary for my child to receive the daily dosage prescribed by his or her doctor and specified on this form. If I make such a request, I shall ensure that I provide the school with additional medication thereafter to enable the school to continue making the scheduled school dosages*

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

TELEPHONE NUMBER: _____

Item No. 19.5550
Revised 1/26/95, atty.
Updated 8/28/01 atty.

Clear all fields

KLEIN INDEPENDENT SCHOOL DISTRICT
NOTICE FOR RELEASE/CONSENT TO REQUEST CONFIDENTIAL INFORMATION

Student's Name: DOB: School:

We are requesting that you authorize Klein ISD (or its agent) to speak with the party specified regarding the above-named student and the release or request of specified records containing confidential information regarding the above-named student.

☐ KLEIN I.S.D. HAS PERMISSION TO RELEASE INFORMATION TO:

Name: Phone:

Address:

City: State: Zip:

☐ KLEIN I.S.D. HAS PERMISSION TO REQUEST INFORMATION FROM:

Name: Phone:

Address:

City: State: Zip:

RECORDS REQUESTED
- ☐ All Educational Records
- ☐ Transcript & Immunizations
- ☐ Academic Assessments
- ☐ Psychological Assessment
- ☐ Comprehensive Assessment
- ☐ Speech/Language Assessment
- ☐ Vocational Assessment
- ☐ OT/PT Assessments
- ☐ Medical Reports
- ☐ ARD/EP Reports
- ☐ Individual Translation Plans
- ☐ Other: _____

PURPOSE OF DISCLOSURE:
☐ Health Planning ☐ Educational Planning ☐ Student Transfer ☐ Other:

If you wish to have more information or if you have any questions, please contact the following staff person:

Name: Phone:

__Yes __No I have been fully informed and understand the school's request for release of the student's records as described above. This information will be released upon receipt of my written request.

__Yes __No I understand that my consent is voluntary and may be revoked in writing at any time. Otherwise, this release is valid for one year from the date of the signature.

Federal regulations require that parents and adult students be provided a full explanation of all procedural safeguards in their native language or other mode of communication each time the district proposes or refuses to initiate or change the identification, evaluation, or educational placement of the child or the provisions of a free appropriate public education.

_____ Date: _____
Signature of Parent, Guardian, Surrogate Parent, or Adult Student

_____ Date: _____
Signature of Interpreter, if used

Please return to: Name Date Mailed/Sent: Address
City/State/Zip