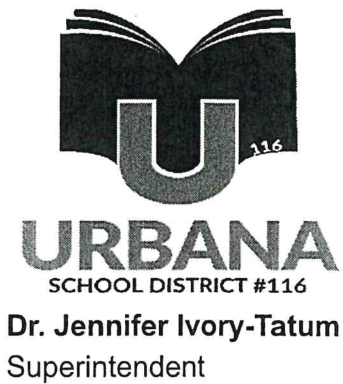
URBANA SCHOOL DISTRICT 116

Jean F. Burkholder Administrative Service Center
1101 E. University Ave., Suite B
Urbana, IL 61802
www.usd116.org



Dr. Jennifer Ivory-Tatum
Superintendent

Dear Parent/Guardian,

We would like your assistance in providing support for your student in regards to seizures. To better meet his/her needs at school we are asking that you please complete the attached forms with assistance from your students Healthcare Provider, and *return to the Main Office or Building Nurse at your students school*:

- ☐ **Seizure Action Plan**
- ☐ **Medication Authorization Form(s)**
  (Please fill out a separate Authorization Form for each type of Medication)
- ☐ **Authorization for Use and Disclosure of Protected Health Info. & Education Records**
  This form will allow us to contact your child's physician should there
  be any questions regarding your child's Seizure Action Plan

All student health information is confidential and will only be shared with staff members that work with your child. Please be aware, the School District Seizure Guidelines require that Emergency Medical Services (911) be contacted for any student suffering a seizure. If you want us to do otherwise, we **MUST** have a copy of the attached Seizure Action Plan completed by your child's Healthcare Provider.

We appreciate your cooperation in helping us to provide for the safety and health of your child while in school. Please contact your Building Nurse or the District Nurse at (217)-384-3549 if you have any questions or concerns.

Sincerely, Amy Marx RN | District Nurse

SEIZURE ACTION PLAN

Name: _______________ Birth Date: _______________

Address: _______________ Phone: _______________

Parent/Guardian: _______________ Phone: _______________

Emergency Contact/Relationship _______________ Phone: _______________

Seizure Information

Seizure Type	How Long It Lasts	How Often	What Happens

Protocol for seizure during school (check all that apply) ☑

- ☐ First aid – **Stay. Safe. Side.**
- ☐ Give rescue therapy according to SAP
- ☐ Notify parent/emergency contact
- ☐ Contact school nurse at _______________
- ☐ Call 911 for transport to _______________
- ☐ Other _______________

First aid for any seizure

- ☐ **STAY** calm, keep calm, **begin timing seizure**
- ☐ Keep me **SAFE** – remove harmful objects, don't restrain, protect head
- ☐ **SIDE** – turn on side if not awake, keep airway clear, don't put objects in mouth
- ☐ **STAY** until recovered from seizure
- ☐ Swipe magnet for VNS
- ☐ Write down what happens _______________
- ☐ Other _______________

When to call 911

- ☐ Seizure with loss of consciousness longer than 5 minutes, not responding to rescue med if available
- ☐ Repeated seizures longer than 10 minutes, no recovery between them, not responding to rescue med if available
- ☐ Difficulty breathing after seizure
- ☐ Serious injury occurs or suspected, seizure in water

When to call your provider first

- ☐ Change in seizure type, number or pattern
- ☐ Person does not return to usual behavior (i.e., confused for a long period)
- ☐ First time seizure that stops on its' own
- ☐ Other medical problems or pregnancy need to be checked

When **rescue therapy** may be needed:

WHEN AND WHAT TO DO

If seizure (cluster, # or length) _______________

Name of Med/Rx _______________ How much to give (dose) _______________

How to give _______________

If seizure (cluster, # or length) _______________

Name of Med/Rx _______________ How much to give (dose) _______________

How to give _______________

If seizure (cluster, # or length) _______________

Name of Med/Rx _______________ How much to give (dose) _______________

How to give _______________

Care after seizure

What type of help is needed? (describe) ____________________

When is student able to resume usual activity? ____________________

Special instructions

First Responders: ____________________

Emergency Department: ____________________

Daily seizure medicine

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

Other information

Triggers: ____________________

Important Medical History ____________________

Allergies ____________________

Epilepsy Surgery (type, date, side effects) ____________________

Device: ☐ VNS ☐ RNS ☐ DBS Date Implanted ____________________

Diet Therapy ☐ Ketogenic ☐ Low Glycemic ☐ Modified Atkins ☐ Other (describe) ____________________

Special Instructions: ____________________

Health care contacts

Epilepsy Provider: ____________________ Phone: ____________________

Primary Care: ____________________ Phone: ____________________

Preferred Hospital: ____________________ Phone: ____________________

Pharmacy: ____________________ Phone: ____________________

My signature ____________________ Date ____________________

Provider signature ____________________ Date ____________________

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Urbana School District #116
1101 E. University Avenue, Suite B, Urbana IL 61802
217-384-3600

- USD#116 MEDICATION AUTHORIZATION / RELEASE FORM -

To be completed by Parent/Guardian:

Students Name ______________________ Birth Date ______________________

Address ______________________ School ______________________

Teacher ______________________Grade ____ Home Ph # ______________________

MEDICATION ______________________ Emergency Ph # ______________________

I hereby confirm my primary responsibility to administer medication to my child. However, in the event that I am unable to do so, I hereby authorize Urbana School District #116 and its employees and agents, in my behalf and stead, to administer to my child (or to allow my child to self administer, while under the supervision of the employees and agents of the School District), lawfully prescribed prescription and non-prescription medication in the manner prescribed by our physician/healthcare provider. I further acknowledge and agree that, when the lawfully prescribed medication is so administered or attempted to be administered, I waive any claims I might have against the School District, its employees and agents arising out of the administration of said medication. In addition, I agree to hold harmless and indemnify the School District, its employees and agents, either jointly or severally, from and against any and all claims, damages, causes of action or injuries, including reasonable attorney's fees and costs expended in defense thereof, incurred or resulting from the administration or attempts at administration of said medication. *I understand that my child is responsible for going to the office or other designated place at the appropriate time for the medication administration.*

Parent Signature: ______________________ Date: ______________________

TO BE COMPLETED BY THE STUDENT'S Physician/Healthcare Provider

Medication______________________ Dosage ______________________

Time to be administered ______________________ Side Effects ______________________

Effective Date: From: ______________________ To: ______________________

Additional Notes:______________________

I hereby confirm the schedule for medication administration described above makes it impossible to provide the required dose outside of school hours.

______________________ ______________________ ______________________

Printed Name of Physician/Healthcare Provider | Signature | Date

______________________ ______________________ ______________________

Physician/Healthcare Providers address | Phone Number | Fax Number

NOTE: MEDICATION MUST BE IN CORRECTLY LABELED CONTAINERS & FOLLOW AGE RECOMMENDATIONS

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The School District will limit its dispensation of medication to cases where failure to take prescribed medication could jeopardize the students' health and/or education and where it is not possible for a parent to administer the medication and the medication cannot be prescribed in doses scheduled for before and after school hours. *Parent help and consideration is essential for the safety of children who must receive medication while at school.*

1. All medications, including non-prescription drugs, given at school shall be prescribed by a physician. A School Medication Authorization Form must be carefully completed each school year. The physician MUST sign the form and a parent/guardian MUST sign the form.

2. A SEPARATE form is required for each medication.

3. Students are not allowed to carry any medication on their person. EXCEPTIONS will be made for students requiring Asthma medication and/or Epinephrine Auto-Injector providing the appropriate documentation from the physician and parent/guardian is completed and received by the school district.

4. Any change in medication dosage or administration MUST have written authorization from the prescriber.

5. Prescription medication MUST be sent in the original container with: students name, name of medication, dosage, schedule of administration, expiration date, prescribers name.

6. Non-Prescription medication MUST be sent in the original container and MUST be age appropriate for the student taking them. A Medication Authorization Form MUST be completed for non-prescription medications.

7. **NO MEDICATIONS WILL BE GIVEN AT SCHOOL UNLESS THE ABOVE GUIDELINES ARE MET**

8. All prescription and non prescription medications MUST be taken to the school office by the parent/guardian where it will be kept in a locked space. EXCEPTIONS will be made for Asthma medication and/or Epinephrine Auto-Injectors (see #3 above).

9. **Please talk with your physician about scheduling medications to avoid school hours whenever possible. Prescription medications which are to be taken 3 times a day normally do not need to be given at school.*

10. It is the parent/guardian's responsibility to pick up all unused medications before the last day of school. Any medication left at school will be disposed of properly by the nurse. We cannot send medication home with students (unless it is an authorized Self-Carry medication).

11. *Please take into consideration if your child will be attending a summer school program and may still need medication while at school, in which case the medication can be left at school at the end of the school year. Please work with your Building Nurse on how the medication will be administered during the summer school program.*

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__________________________ __________________________________ __________________________

Physician/Healthcare Providers address Phone Number Fax Number

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Authorization for Use and Disclosure of Protected Health Information and Education Records

Patient/Student Name: ______________________________ **Date of Birth:** ________________

I hereby authorize: ______________________________
____
____

to disclose protected health information and/or educational records to:

____
____
____

_____ Check here if authorization is given for the parties listed above to mutually exchange the information described below.

Description:
The health information to be disclosed consists of (check all that apply):

_____ Any and all records in the possession of ____________________ including mental health, HIV and/or substance abuse records. (Cross out any item that you do not authorize to be released)
_____ Records regarding treatment for the following condition or injury ____________________
_____ Records covering the period of time between ________________ and ________________
_____ Other (be specific, including dates) ____

The education information to be disclosed consists of (check all that apply):

_____ Any and all educational records, including special education records
_____ Records covering the period of time between ________________ and ________________
_____ Other ____

Purpose: This information is to be disclosed at the individual's request and will be used for the following purpose(s) (check all that apply)

_____ Educational evaluation and program planning
_____ Health assessment and planning for health care services and treatment in school
_____ Medical evaluation and treatment
_____ Other ____

This authorization is valid for one calendar year and will expire on ________________. I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent. I understand that my revocation of this authorization will not be effective for actions taken by the school district or health care provider in reliance upon my authorization and prior to notice of my revocation. I understand that failing to authorize disclosure of records may adversely impact the educational programming and/or medical treatment for my child. I recognize that health records, once received by the school district, may not be protected by the HIPAA Privacy Rule, but will become education records protected by the Family Educational Rights and Privacy Act. I also understand that if I refuse to sign, such refusal will not interfere with my child's ability to obtain health care. I also understand that I have the right to inspect and copy educational records and to challenge their contents.

Parent Signature ______________________________ Date ____________

Student Signature* ______________________________ Date ____________

*student signature required if the minor student is over age 12 and if this authorization is for the release of mental health records