Holy Family Regional School 2300 Beasley Avenue, Huntsville, Al 35816
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Formulario de Autorización, Instrucciones y Plan de Manejo del Medicamento Otorgado por el Médico/Padre de Familia a la Escuela (PPA), Plan Individual de Cuidados de Salud (IHP), Plan de Acción de Emergencia (EAP), y Plan de Acción para el Salón de Clases (CAP) por CONVULSIONES

1. **(IHP) Plan Individual de Cuidados de Salud/(EAP) Plan de Acción de Emergencia/(CAP) Plan de Acción para el Salón de Clases**
   - Sección I – Padre/Tutor debe completar.
   - Sección II – Médico, Asistente del Médico, o Enfermera(o) calificada(o) debe firmar y escribir la fecha.
   - Firmas – Padre de Familia/Tutor, Médico, Asistente del Médico, y/o Enfermera(o) Calificada(o) debe firmar y escribir la fecha.

**El Consejo de Enfermería de Alabama exige que lo siguiente sea llenado en su totalidad para cada (PPAs) Medicamento/Dosis.*

2. **Formulario de Autorización Otorgado a la Escuela por el Médico/Padre de Familia (PPA).**
   - **Sección de Autorización del Médico que Receta: (Medicamentos con y/o sin Receta)**
     - **Cada espacio vacío debe ser llenado** para incluír: medicamento, dosis, horario, vía de suministro (oral, nasal, etc.) fechas de comienzo y terminación, razón, instrucciones especiales, firma y fecha.
     - Ningún Medicamento será aceptado ni suministrado si el formulario (PPA) está incompleto y/o incorrecto.
     - Llene un Formulario (PPA) para cada medicamento y para cada dósis.
     - Fecha de Comienzo y Fecha de Terminación – Por favor mencione las fechas específicas.
     - Eso de *"Usarse de acuerdo a las instrucciones"*, no será aceptado – debe ser específico.
     - Horario de suministro – *"como sea necesario"*, por favor incluya parámetros de tiempo (por ejemplo: cada 4 horas si es necesario, etc.), y
     - El Auto suministro/hecho de llevar consigo medicamentos – Unicamente será permitido para tratar y/o prevenir emergencias.
   - **Sección del Padre/Tutor.**
     - **Sección de Información del Estudiante –** El Padre/Tutor debe contestar por escrito cada pregunta incluyendo: alergias, peso y fecha de nacimiento,
     - **Sección de Autorización del Padre –** El Padre/Tutor debe firmar, poner la fecha y
     - **Sección de Autorización para el Auto suministro de medicamentos –** El Padre/Tutor debe firmar y poner la fecha donde autoriza a su hijo/a, el auto suministro y/o el hecho de llevar consigo el medicamento a la escuela.

El Padre /Tutor debe traer (directamente a la enfermera de la escuela ó a la persona asignada para suministrar medicamentos), un Formulario de Autorización del Médico y/o del Padre de Familia (PPA(s)); medicamento(s), e instrucciones de suministro. Los Estudiantes, no deben, a menos que estén autorizados para auto suministrarse y/o llevar consigo, su(s) propio(s) medicamento(s). Todo medicamento (incluyendo recetado y no recetado) debe ser contado y registrado cada vez.

Medicamentos vencidos: Por favor esté pendiente de las fechas de vencimiento de sus medicamentos. Usted será notificado(a) cuando el medicamento de su hijo(a) se venza.

Fin del Año Escolar: Todo medicamento debe ser recogido y firmar de recogido, al final del año escolar. Después de este tiempo, todo medicamento dejado u olvidado en la clínica de la escuela será desechado de acuerdo al reglamento estatal y federal.

Sinceramente,

Enfermera de la Escuela

Si usted ha recibido este paquete por equivocación, o si la condición médica de su estudiante no necesita de un plan de emergencia, por favor, firme y regrese este formato a la maestra de su hijo(a) o a la enfermera de la escuela.

❑ Recibido por equivocación ❑ La condición médica del estudiante no necesita ni medicamento, ni plan de emergencia.

Nombre del Estudiante: _____

Comentarios: _____

Firma del Padre/Tutor: _____ Fecha: _____

HCS School: _____ School Year: _____ School Hours: _____

Stop Date: _____ Extracurricular Hours: _____

MANAGEMENT PLAN: SEIZURES WITH VNS AND/OR DIASTAT

Individualized Healthcare Plan (IHP) / Emergency Action Plan (EAP) / Classroom Plan(CAP) / Extracurricular Plan / Bus Plan

SECTION I – Parent (Please Print): **SEIZURE TYPE(S):** _____

Student Name: _____ DOB: _____ Teacher/Grade: _____

Known Allergies/Triggers: _____ Wt. _____

Medications Taken at Home: _____

Bus Transportation to and from school: Bus # a.m. _____ Bus # p.m. _____

Emergency Contact: _____ (Name) _____ (Cell #) _____ (Home #) _____ (Work #)

Emergency Contact: _____ (Name) _____ (Cell #) _____ (Home #) _____ (Work #)

Physician: _____ Phone #: _____

Preferred Hospital in Case of Emergency: _____

Insurance Provider: _____ (optional) Policy/Group # _____ (optional)

SECTION II – Physician (Please Print)

Does student experience an AURA before seizures? YES / NO What? _____

Behavior or activity student usually exhibits during seizures: _____

SCHOOL PLAN:

IF YOU SEE THIS…	DO THIS…
Seizure activity is noted. **Student has *VNS?** Yes / No Swipe magnet at onset of seizure and repeat every ____ seconds times_____. **Student has *Diastat ordered at school?** Yes / No ***Diastat** ____mg administer after ____minutes or if ___ seizures within ____ minutes.	1. Remain with student, provide privacy, clear area, and swipe VNS as ordered, 2. If tonic/clonic seizure, place student in side-lying position, 3. Do not put anything in mouth or restrict student, 4 Call parent / guardian / emergency contact, student may be required to go home, 5. Call 911 if seizure lasts > _____ minutes, follow EAP/IHP plan, 6. Licensed nurse or parent will administer emergency medication as prescribed by MD: **Medication:** _____ **Dose:** _____, 7. Document time and specifics of seizure, if not transported to ER and Diastat was administered, parent / guardian / emergency contact will take student home.

* ALL MEDICATIONS/VNS GIVEN AT SCHOOL REQUIRE A SCHOOL MEDICATION PRESCRIBER/PARENT AUTHORIZATION (PPA) SIGNED BY THE PRESCRIBER

FIELD TRIPS: Emergency medications *should NOT be left* in a backpack on the bus or with a teacher who is not with the student.

BUS PLAN: IF YOU SEE THIS…	DO THIS…
Seizure activity is noted. ***VNS/Diastat** will not be available for administration during bus transport.	1. Bus driver pull over, 2. Call 911 and call parent/guardian or emergency contact, 3. Remain with student, provide privacy if possible, side-lying position and do not put anything in mouth or restrict student, 4. Document time and specifics of seizure, transport as needed.

EXTRACURRICULAR PLAN: Medication Assistant/Sponsor will follow Management Plan and PPA.

I UNDERSTAND AND AGREE WITH THIS MANAGEMENT PLAN:

I give permission for my child to be transported to the hospital indicated on this form, in the event of an emergency and for the release of my child's medical information to be shared with appropriate persons on an as-needed basis to insure the health and safety of my child. A nurse will not be present on the school bus, private car, or extracurricular activity.

_____ Physician Signature Date _____ Parent Signature Date _____ Student Signature Date _____ Nurse Signature Date

FOR SCHOOL NURSE USE ONLY

Medication	Self-Carry?	Self-Administer?	Expiration	Location of Medication

HCS School: _____ Start Date: _____ School Hours: _____

Stop Date: _____ Extracurricular Hours: _____

MANAGEMENT PLAN: SEIZURES WITH KLONOPIN(CLONAZEPAM) AND/OR VNS

Individualized Healthcare Plan (IHP) / Emergency Action Plan (EAP) / Classroom Plan(CAP) / Extracurricular Plan / Bus Plan

SEIZURE TYPE(S): _____

SECTION I – Parent (Please Print):

Student Name: _____ DOB: _____ Teacher/Grade: _____

Known Allergies/Triggers: _____ Wt. _____

Medications Taken at Home: _____

Bus Transportation to and from school: Bus # a.m. _____ Bus # p.m. _____

Emergency Contact: _____ (Name) _____ (Cell #) _____ (Home #) _____ (Work #)

Emergency Contact: _____ (Name) _____ (Cell #) _____ (Home #) _____ (Work #)

Physician: _____ Phone #: _____

Preferred Hospital in Case of Emergency: _____

Insurance Provider: _____ (optional) Policy/Group # _____ (optional)

SECTION II – Physician (Please Print)

Does student experience an AURA before seizures? YES / NO What? _____

Behavior or activity student usually exhibits during seizures: _____

School Plan:

IF YOU SEE THIS...	DO THIS...
Seizure activity is noted. **Student has *VNS? Yes / No** Swipe magnet at onset of seizure and repeat every minute times_____	1. Remain with student, provide privacy, clear area, swipe VNS as ordered 2. If tonic/clonic seizure, place student in side-lying position, 3. Do not put anything in mouth or restrict student, 4 Call parent / guardian / emergency contact, student will go home. 5. Call 911 if seizure lasts _____ minutes, follow EAP/IHP plan.
Student has *Clonazepam/Klonopin ordered at school? Yes / No ***Clonazepam/Klonopin ____ mg given for** seizure lasting ____ minutes or if student has ____ seizures in ____ minutes. Administer inside cheek at gum line with gloved hand. **DO NOT** insert finger into student's mouth.	6. Licensed nurse, Medication Assistant or parent will administer ***Clonazepam/Klonopin** as prescribed by MD. Always call 911 when medication is administered. 7. Document time and specifics of seizure, if not transported to ER, parent / guardian / emergency contact will take student home.

*** ALL MEDICATIONS/VNS GIVEN AT SCHOOL REQUIRE A SCHOOL MEDICATION PRESCRIBER/PARENT AUTHORIZATION (PPA) SIGNED BY THE PRESCRIBER**

FIELD TRIPS: Emergency medications *should NOT be left* in a backpack on the bus or with a teacher who is not with the student.

Bus Plan: IF YOU SEE THIS...	DO THIS...
Seizure activity is noted. *VNS/Clonazepam/Klonopin will not be available for administration during bus transport.	1. Bus driver pull over 2. Call 911 and call parent/guardian or emergency contact, 3. Remain with student, provide privacy if possible, side-lying position and do not put anything in mouth or restrict student, 4. Document time and specifics of seizure, transport as needed.

EXTRACURRICULAR PLAN: Medication Assistant/Sponsor will follow Management Plan and PPA.

I UNDERSTAND AND AGREE WITH THIS MANAGEMENT PLAN:

I give permission for my child to be transported to the hospital indicated on this form, in the event of an emergency and for the release of my child's medical information to be shared with appropriate persons on an as-needed basis to insure the health and safety of my child. A nurse will not be present on the school bus, private car, or extracurricular activity.

_____ Physician Signature Date _____ Parent Signature Date _____ Student Signature Date _____ Nurse Signature Date

FOR SCHOOL NURSE USE ONLY

Medication	Self-Carry?	Self-Administer?	Expiration	Location of Medication

HCS School: _____ School Year: _____ School Hours: _____

Stop Date: _____ Extracurricular Hours: _____

MANAGEMENT PLAN: SEIZURES WITHOUT MEDICATION AT SCHOOL

Individualized Healthcare Plan (IHP) / Emergency Action Plan (EAP) / Classroom Plan (CAP) / Extracurricular Plan / Bus Plan

SEIZURE TYPE(S): _____

SECTION I – Parent (Please Print):

Student Name: _____ DOB: _____ Teacher/Grade: _____

Known Allergies/Triggers: _____ Wt. _____

Medications Taken at Home: _____

Bus Transportation to and from school: Bus # a.m. _____ Bus # p.m. _____

Emergency Contact: _____ (Name) _____ (Cell #) _____ (Home #) _____ (Work #)

Emergency Contact: _____ (Name) _____ (Cell #) _____ (Home #) _____ (Work #)

Physician: _____ Phone #: _____

Preferred Hospital in Case of Emergency: _____

Insurance Provider: _____ (optional) Policy/Group # _____ (optional)

SECTION II – Parent (Please Print)

Does student experience an AURA before seizures? YES / NO What? _____

Behavior or activity student usually exhibits during seizures: _____

School Plan:

IF YOU SEE SEIZURE ACTIVITY…	DO THIS…
• Staring with no response for a few seconds • Uncontrolled shaking/twitching of limbs for up to a few minutes • Trance-like state with purposeless movements • Loss of consciousness with generalized violent, muscle contractions and possible incontinence of urine **Seizure activity is noted.** **Student has *VNS? Yes / No** Swipe magnet at onset of seizure and repeat every___ minute times_____	• Report to nurse or parent if requested. Note time/duration, • Report to nurse. Nurse will contact parent. Note time/duration, • Report to nurse, • Have someone contact nurse, • Remain with student; provide privacy if possible, side-lying position. Do not put anything in mouth or restrict student, • Move furniture away from student and loosen any tight clothing to avoid injury, • Maintain clear airway, • Provide privacy – clear other students from area if possible, • Note time/duration of seizure activity. ***For seizure activity greater than 5 minutes call 911,*** • Notify parents.

DO NOT…	***Call 911 first ONLY if:***
• Call 911 until the nurse has assessed as parent may wish to transport student. • Put anything in mouth • Attempt to hold down or try to waken student • Move to another location unless present location presents a danger • Ask student to sit up and walk until nurse has assessed	• The student is injured as a result of the seizure (example: fall), • The nurse is not in the building, • ***Seizure activity greater than 5 minutes call 911.***

* ALL MEDICATIONS GIVEN AT SCHOOL REQUIRE A SCHOOL MEDICATION PRESCRIBER/PARENT AUTHORIZATION (PPA) SIGNED BY THE PRESCRIBER

FIELD TRIPS: Supplies *should NOT be left* in a backpack on the bus or with a teacher who is not with the student.

Bus Plan: IF YOU SEE THIS…	DO THIS…
Seizure activity is noted.	1. Bus driver pull over, 2. Call 911 and call parent/guardian or emergency contact, 3. Remain with student, provide privacy if possible, side-lying position and do not put anything in mouth or restrict student, 4. Document time and specifics of seizure, transport as needed.

EXTRACURRICULAR PLAN: Medication Assistant/Sponsor will follow Management Plan and PPA.

I UNDERSTAND AND AGREE WITH THIS MANAGEMENT PLAN:

I give permission for my child to be transported to the hospital indicated on this form, in the event of an emergency and for the release of my child's medical information to be shared with appropriate persons on an as-needed basis to insure the health and safety of my child. A nurse will not be present on the school bus, private car, or extracurricular activity.

_____ Physician Signature Date _____ Parent Signature Date _____ Student Signature Date _____ Nurse Signature Date

ALABAMA STATE DEPARTMENT OF EDUCATION
SCHOOL MEDICATION PRESCRIBER/PARENT AUTHORIZATION
FOR VAGUS NERVE STIMULATOR (VNS)

School Year: _____-_____

STUDENT INFORMATION

Student's Name _____ **School:** _____

Date of Birth: ____/____/____ **Grade** _____ **Teacher** _____

☐ **Known drug allergies/reactions** **If drug allergies, list:** _____ **Weight:** _____ **pounds**

PRESCRIBER AUTHORIZATION

(To be completed by licensed healthcare provider)

START DATE: _____ **STOP DATE:** _____

Procedure: Swiping magnet over student's VNS

Reason for procedure: To shorten duration of, or stop, seizure activity.

How& frequency r/t swipe delivery: Swipe magnet over VNS for full 1-2 second time period, at onset of seizure activity.

Repeat swipe X _____ if seizure activity does not cease after _____ minute(s).

If magnet is held in place over the VNS for longer than 60 seconds at one time, the generator will be turned off until the magnet is removed. Once magnet is removed, the device will resume its normal cycle.

Do you recommend the magnet be kept "on person" by the student? ☐ Yes ☐ No
If "no", storage location of magnet will be identified in student's Individualized Healthcare Plan.

Potential Contradictions/Adverse Reactions: _____

_____
Printed Name of Licensed Healthcare Provider

_____ _____ _____ _____
Signature of Licensed Healthcare Provider **Date** **Phone** **Fax**

PARENT AUTHORIZATION

I authorize the School Nurse, the registered nurse (RN) or licensed practical nurse (LPN) to assist my child in the above procedure, and to delegate to trained, unlicensed school personnel, the task of assisting my child with the above prescribed procedure, in accordance with administrative code practice rules. I understand that additional parent/prescriber signed statements will be necessary if the procedure is changed. I also authorize the School Nurse to talk with the licensed healthcare provider should a question come up about the procedure.
Procedure equipment or supplies must be registered with the school nurse or his/her designee.

Signature of Parent _____ **Date** _____ **Phone** _____ **Cell** _____

ALABAMA STATE DEPARTMENT OF EDUCATION

SCHOOL MEDICATION PRESCRIBER/PARENT AUTHORIZATION

School Year: _____-_____

STUDENT INFORMATION

Student's Name: _____ **School:** _____

Date of Birth: ____/____/_____ Age: _____ Grade: _____ Teacher: _____

❑ **No known drug allergies---if drug allergies list:** _____ Weight: _____pounds

PRESCRIBER AUTHORIZATION (To be completed by licensed healthcare provider)

Medication Name: _____ **Dosage:** _____ **Route:** _____

Frequency/Time(s) to be given: _____ **Start Date:** ___/___/___ **Stop Date:** ___/___/___

Reason for taking medication: _____

Potential side effects/contraindications/adverse reactions: _____

Treatment order in the event of an adverse reaction: _____

SPECIAL INSTRUCTIONS:

Is the medication a controlled substance? Yes ❑ No ❑

Is self- medication permitted and recommended? Yes ❑ No ❑

If "yes" I hereby affirm this student has been instructed
On proper self-administration of the prescribe medication.

Do you recommend this medication be kept "on person" by student? Yes ❑ No ❑

Printed Name of Licensed Healthcare Provider: _____ **Phone:** ( ) _____-_____ **Fax:** _____-_____

Signature of Licensed Healthcare Provider: _____ **Date:** _____

PARENT AUTHORIZATION

I authorize the School Nurse, the registered nurse (RN) or licensed practical nurse (LPN) to administer or to delegate to unlicensed school personnel the task of assisting my child in taking the above medication in accordance with the administrative code practice rules. I understand that additional parent/prescriber signed statements will be necessary if the dosage of medication is changed. I also authorize the School Nurse to talk with the prescriber or pharmacist should a question come up with the medication.

Prescription Medication must be registered with School Nurse or trained Medication Assistants. Prescription medication must be properly labeled with student's name, prescriber's name, name of medication, dosage, time intervals, route of administration and the date of drug's expiration when appropriate.

Over the Counter Medication must be registered with the School Nurse or Trained Medication Assistant, OTC's in the original, unopened and sealed container. Local Education Agency Policy for OTC medication to be followed:

Parent's/Guardian's Signature: _____ **Date:** ___/___/___ **Phone:** ( ) _____-_____

SELF-ADMINISTRATION AUTHORIZATION

(To be completed ONLY if student is authorized to complete self-care by licensed healthcare provider.)

I authorize and recommend self-medication by my child for the above medication. I also affirm that he/she has been instructed in the proper self-administration of the prescribed medication by his/her attending physician. I shall indemnify and hold harmless the school, the agents of the school, and the local board of education against any claims that may arise relating to my child's self-administration of prescribed medication(s).

Signature of Parent: _____ **Date:** ___/___/_____ **Phone:** ( ) _____-_____