



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

- o Sección I – Padre/Tutor debe completar.
- o Sección II – Médico, Asistente del Médico, o Enfermera(o) calificada(o) debe firmar y escribir la fecha.
- o 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).

- o **Sección de Autorización del Médico que Receta: (Medicamentos con y/o sin Receta)**
 - Cada espacio vacío debe ser llenado para incluir: 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 dosis.
 - 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 – Únicamente será permitido para tratar y/o prevenir emergencias.
- o **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: _____

School: _____ School District: _____ School Hours: _____
 School Nurse _____ Start Date: _____ Extracurricular Hours: _____
 School Nurse Phone# _____ Stop Date: _____ Extracurricular Activity: _____

MANAGEMENT PLAN for SEIZURES TYPES:

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

SECTION I –PARENT (Please, Print)

IEP? YES NO 504 PLAN? YES NO

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

Student Home Address: _____

Known Allergies/Triggers: _____ WT _____ HT _____

Medications Taken at Home: _____

Potential Side-Effects of Home Meds: _____

Bus Transportation YES NO Bus # a.m. _____ Bus # p.m. _____ Fieldtrip/Extracurricular Bus Transportation YES NO

Parent/Guardian Contact: _____

Parent/Guardian Contact: Name _____ Cell # _____ Home # _____ Work # _____

Parent/Guardian Contact: Name _____ Cell # _____ Home # _____ Work # _____

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

Physician: _____ Phone#: _____ Fax#: _____

Physician Address: _____ Preferred Hospital: _____

Insurance Provider: _____ Policy/Group # _____

(optional)

(optional)

SECTION II – PHYSICIAN (Please, Print)

EMERGENCY ACTION PLAN (EAP)

A signed medication PRESCRIBER/PARENT AUTHORIZATION (PPA) FORM is required for each medication

Is a medication PRESCRIBER/PARENT AUTHORIZATION (PPA) on file for this student? YES NO

If student "self-carries" medication, a "back up" medication may be kept in clinic? YES NO

Does student experience an AURA before seizures? YES NO If YES what? _____

- Behavior/activity student usually exhibits during seizures:**
- Stiffening & jerking movements
 - Tremors or twitching
 - Repeated blinking of eyes
 - Rapid eye movements
 - Lip smacking
 - Tongue movements
 - Repeated non-purposeful movements
 - Staring
 - Other: _____

The severity of symptoms can change quickly and potentially progress to a life-threatening situation.

IF YOU SEE THIS...	DO THIS...
<p>Onset of Seizure Activity →</p> <p>Student has *VNS? <input type="checkbox"/> YES <input type="checkbox"/> NO Swipe magnet at onset of seizure and repeat every ____ seconds times _____</p> <p>Seizure Activity Continues →</p> <p>*Klonopin/Clonazepam ordered at school? <input type="checkbox"/> YES <input type="checkbox"/> NO Klonopin/Clonazepam ____mg administer after ____ minutes or if ____ seizures within ____ minutes Medication not required on the bus</p> <p>*Diastat ordered at school? <input type="checkbox"/> YES <input type="checkbox"/> NO Diastat ____mg administer after ____ minutes or if ____ seizures within ____ minutes Medication not required on the bus</p> <p>*Versed ordered at school? <input type="checkbox"/> YES <input type="checkbox"/> NO Versed ____mg administer after ____ minutes or if ____ seizures within ____ minutes Medication not required on the bus</p>	<p>If VNS: 1st swipe with magnet per prescriber's order. Follow steps below and repeat VNS as ordered If NO VNS, follow steps below:</p> <ul style="list-style-type: none"> • Remain with student and provide verbal reassurance, notify School Nurse • Provide privacy, do not restrain student, do not put anything in student's mouth • Note time at onset of seizure activity, duration, activity noted and document on seizure log • Seizure activity stops, contact Parent/Guardian/Emergency Contact to inform of seizure <p>If seizure activity continues, call for School Nurse and continue to monitor student</p> <ul style="list-style-type: none"> • Ease student to the floor and place student in side-lying position • Cushion student's head and remove surrounding objects that could cause injury • Medication Assistant/Licensed Nurse/Parent Guardian will administer Klonopin/Clonazepam per PPA • Licensed Nurse or Parent/Guardian will administer Diastat or Versed per PPA • Continue to document and note time emergency medication was given • Call 911 if emergency medication is given, student injury or for seizure > ____ min • Call Parent/Guardian/Emergency Contact • If NOT transported to ER and emergency medication was administered, Parent/Guardian/Emergency Contact will take student home

I UNDERSTAND AND AGREE WITH THIS MANAGEMENT PLAN:

I give permission for my child to be transported to the hospital, 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 & 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 / VNS Magnet	Self-Carry?	Self-Administer?	Expiration	Location of Medication

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 _____

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: () _____ - _____