Holy Family Regional School 2300 Beasley Avenue, Huntsville, Al 35816
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Instructions for the School Medication Prescriber/Parent Authorization Form (PPA) & Management Plan, (IHP) Individualized Healthcare Plan, (EAP) Emergency Action Plan, and (CAP) Classroom Action Plan for SEIZURES

1. **(IHP) Individualized Healthcare Plan/(EAP) Emergency Action Plan/(CAP) Classroom Action Plan**
   - Section I – Parent/Guardian must complete.
   - Section II – Physician, Physician's Assistant, or Nurse Practitioner must complete.
   - Signatures - Parent/Guardian, Physician, Physician's Assistant, and/or Nurse Practitioner must sign and date.

**Alabama Board of Nursing requires the following to be completed on all (PPAs) for each Med/Dose*

2. **School Medication Prescriber/Parent Authorization Form (PPA)**
   - **Prescriber Authorization Section: (Prescription & Over-the-Counter Medications)**
     - **Every blank must be completed** to include: med, dosage, time, route, start and stop dates, reason, special instructions, sign and date,
     - Med(s) will not be accepted or administrated with an incomplete and/or incorrect PPA,
     - Complete one PPA for each med & each dose,
     - Start Date and Stop Date - Please list specific dates,
     - Use as Directed instructions will not be accepted - must be specific,
     - Frequency/Time(s) to be given – "as needed", please include time parameters (example: every 4 hours as needed), and
     - Self-Administer/Self-Carry - Only med(s) to prevent &/or treat medical emergencies are acceptable.
   - **Parent/Guardian Section**
     - **Student Information Section**- Parent/Guardian must complete every question including: allergies, weight and birth date,
     - **Parent Authorization Section**- Parent/Guardian must sign and date, and
     - **Self-Administration Authorization Section**- Parent/Guardian must sign and date to allow student to self-medicate and/or self-carry approved med at school.

Parent/Guardian must bring in PPA(s), medication(s), and management plan(s) directly to the school nurse or designated medication assistant. Students, unless prescribed to 'Self-Administer/Self-Carry', may not bring in their own medication(s). All medications (to include over-the-counter & prescription) must be counted and logged-in each time.

Expired Medication(s): Please be aware of medication expiration dates. You will be notified when your child's med expires.

End of School Year: All medication(s) must be signed out at the end of the school year. Medication(s) left in the clinic after that time will be discarded according to federal and state guidelines.

Sincerely,

School Nurse

If you have received this packet in error, or if your student's medical condition does not require emergency planning, please sign below and return this form to your child's teacher or school nurse.

☐ Received in error ☐ Student's medical condition does not require medication and/or emergency planning

Student Name: ______________________________

Comments: ______________________________

Parent/Guardian Signature: ______________________ Date: ____________

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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: ______ 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: ______ (optional) Policy/Group # ______ (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...
Onset of Seizure Activity → Student has *VNS? ❑ YES ❑ NO Swipe magnet at onset of seizure and repeat every ____ seconds times_____	If **VNS**: 1st swipe with magnet per prescriber's order. Follow steps below and repeat VNS as ordered If **NO VNS**, follow steps below: • 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
Seizure Activity Continues → *Klonopin/Clonazepam ordered at school? ❑ YES ❑ NO Klonopin/Clonazepam ____mg administer after ____ minutes or if ___ seizures within ____ minutes **Medication not required on the bus** *Diastat ordered at school? ❑ YES ❑ NO Diastat ____mg administer after ____ minutes or if ___ seizures within ____ minutes **Medication not required on the bus** *Versed ordered at school? ❑ YES ❑ NO Versed ____mg administer after ____ minutes or if ___ seizures within ____ minutes **Medication not required on the bus**	If **seizure activity continues**, **call for School Nurse** and continue to monitor student • 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

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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:** ( ) ______-______