Clarksville Community School Corporation Health Services

Primary Care Provider (PCP) Authorization: Seizure Monitoring (Side One)

2024-2025 School Year

Student Name: _____ **Date of Birth:** _____ **School:** _____

TYPE OF SEIZURE

☐ Tonic-clonic (Grand Mal)

☐ Absence (Petit Mal)

☐ Simple Partial

☐ Complex Partial

☐ Other _____

Does this student have a Vagus Nerve Stimulator? ☐ Yes ☐ No
IF child as **VAGUS NERVE STIMULATOR** please specify when to use and how often (i.e. Q Minute X 4 then administer Diastat:

_____

VNS magnet should be kept with the student at all times.

Does the student have Diastat? ☐ Yes ☐ No

IF child has **DIASTAT**, please specify:
DOSE: _____ **MG PER RECTUM AND ADMINISTER AT:**

☐ Onset of seizure

☐ _____ minutes after onset of seizure

☐ Other: _____

Diastat will be kept in a secured area in the office or nurse's office (if applicable), or in the classroom with trained adult.

- Diastat will not be transported on the bus, EXCEPT for field trips ONLY. During the field trip the Diastat should be kept and administered by trained staff ONLY.

Will this child take any other oral/g-tube/nasal **EMERGENCY** seizure medication(s) **AT SCHOOL?** ☐ Yes ☐ No

IF YES, please write in the **EMERGENCY** seizure medication(s) instructions for school (name, dose, route, time, etc.)

_____

_____

Please complete both sides of this form, Form MUST be signed by Health Care Provider AND parent/guardian.

EMERGENCY PLAN OF ACTION

1. Time the seizure.
2. Ease the student to the floor, remove hazards in the area, and turn student onto his/her side to keep airway open.
3. Use vagus nerve stimulator (VNS) and/or rectal Diastat as indicated.
4. Call EMS 911: if Diastat is administered or if **any** seizure lasts longer than five minutes; if there is any continued, progressive respiratory distress; if anther seizure starts right after the first; if school has no record of student history of seizures, and/or if this PCP form indicates in writing to call at onset of seizure.
5. However, if Diastat is administered and a nurse is available in the building to monitor the stable student, the nurse may observe the student until parent/guardian arrives. If unable to reach parent/guardian within 30 minutes of administering Diastat and/or parent/guardian are unable to get to the school within one hour of administering Diastat, EMS 911 will be called.
6. Notify school personnel trained in CPR/First Aid to respond and initiate CPR if needed prior to EMS arrival.
7. Notify parent/guardian.
8. If EMS is called the student must be transported via EMS to emergency facility, or parent/guardian must sign release with EMS and then parent/guardian assumes responsibility for student. The student may not return to school that day.
9. When student is transported via EMS, CCSC staff must ride with student unless parent and/or emergency contact accompanies them.
10. Document all seizure activity.
11. If the student requires medical treatment while on the bus, the driver will contact EMS.
12. Other:_____

	Initials/Date
Reviewed by Health Services	_____
Entered by Health Services	_____
School received/sent to Health Services & School Staff	_____

Clarksville Community School Corporation Health Services

Primary Care Provider (PCP) Authorization: Seizure Monitoring (Side Two)

2024-2025 School Year

Student Name: _____ **Date of Birth:** _____ **School:** _____

Please specify likely characteristics.						Other/Comments
Duration	Specify seconds, minutes, etc.					
Aura	Is there an Aura? ☐ Yes ☐ No Conditions or behaviors that usually precede the seizures:					
Extremities	(circle one)	Limp	Flexed	Extended	Jerking	
	Right/Left Arm	☐	☐	☐	☐	
	Right/Left Leg	☐	☐	☐	☐	
Eyes	Rolled Back			☐ Yes	☐ No	
	Twitching Back and Forth			☐ Yes	☐ No	
	Looking to Right/Left (circle one)			☐ Yes	☐ No	
	Staring			☐ Yes	☐ No	
Mouth	Drawn to Right/Left (circle one)			☐ Yes	☐ No	
	Bites Tongue/Cheek			☐ Yes	☐ No	
	Teeth Clenched			☐ Yes	☐ No	
Breathing	Noisy/Loud Breathing			☐ Yes	☐ No	
	Shallow Breathing			☐ Yes	☐ No	
Other	Incontinent Urine/Stool			☐ Yes	☐ No	
	Drooling/Vomiting			☐ Yes	☐ No	

THIS FORM MUST BE SIGNED BY HEALTH CARE PROVIDER AND PAERNT/GUARDIAN.

_____ _____ _____ _____ _____

Printed Name of MD, APRN, or PA **Signature of MD, APRN, or PA**

***Parent/guardian hereby acknowledges that if this medication is not self-administered, it will most likely be administered by trained CCSC personnel. Parent/guardian acknowledges and agrees when authorizing their child to attend a school sponsored field trip this medication may also be administered by trained, unlicensed CCSC personnel. By signing this form, the parent/guardian acknowledges that the Clarksville Community School Corporation, its employees and agents shall incur no liability as a result of any injury sustained by the student from any reaction to any medication to treat a seizure or the administration of such medication, unless the injury is the result of negligence or misconduct on behalf of the school or its employees. The parent/guardian shall hold harmless the school and its employees against any claims made for any reason to any medication to treat a seizure or the administration of such medication unless the reaction is due to negligence or misconduct on behalf of the school or its employees. Also, I hereby give permission for the health care provider completing and signing this form to verify this information with CCSC and consult with CCSC staff regarding this information.**

_____ _____ _____

Signature of Parent/Guardian Telephone # Date

_____ _____ _____

Emergency Contact Telephone # Relationship

Please return to:
CCSC School Nurse
700 N Randolph Ave, Clarksville, IN 47129
Telephone # (812)282-1447, ext 2006 Fax # (812)280-5019