Kimberly Area School District

Health Services

Cindy Vandenberg, School Nurse 423-4144
Kathy Verstegen, School Nurse 423-4147
Erin Cannon, School Nurse 423-4150

Student's Picture

PO Box 159 Combined Locks, WI 54113 Fax (920) 788-7919

Student's Name:	DOB:	Date:
School Attending:	Grade:	Bus Student: Yes No

Health Condition: Seizure – Emergency Care

PROCEDURE:

1. Child should never be left alone.
   - Send someone to get another adult.
   - Contact parent immediately.
   - If unable to reach parent, contact emergency person identified on student information card.
2. Loosen all restrictive clothing around neck.
   - Position student on their side, if possible, to prevent choking on saliva or vomit.
   - Do not insert anything in child's mouth including your fingers.
   - Place soft object under head.
   - Administer diastat if available and trained staff member is present.
3. Observe and record the seizure.
   - Length of time seizure started and when it stopped.
   - Any movement of body parts, separate or all extremities involved (any jerking or continuous movement).
   - Any breathing problems or cyanosis (appears blue).
   - Any incontinence or stool or urine.
4. Call ambulance if:
   - Diastat is given.
   - Seizure lasts longer than 5 minutes or seizure lasts less than 5 minutes and is followed by another seizure.
   - Parent or emergency contact can not be reached.
   - Other _____
5. Comfort and reassure child after seizure allowing them to rest.

DOSAGE

Diastat Acudial: give: dose/route/time of day _____

Possible Side Effects: _____

Direct contact shall be made with the physician should the student receiving the medication develop any of the following conditions or reactions to the medication (if none, so state): _____

Medication Consent: I hereby give permission to designated trained school personnel to give medication to my child during the school day, including when away from school property on official school business, according to the written instructions of the doctor as shown on this form. I also hereby agree to give my permission to the school nurse and/or school personnel to contact the child's physician if needed.

I hereby give permission to designated school personnel to notify other appropriate school personnel and classroom teachers of medication administration and possible adverse effects of the medication.

I further agree to hold the Kimberly Area School District, and the KASD employee(s) who is (are) administering the medication harmless in any or all claims arising from the administration of this medication at school.

I agree to notify the school at the termination of this request or when any change in the above orders is necessary.

I have reviewed the health plan for my child. (Please choose below)

_____ The plan is correct as written.

_____ The plan is correct with the changes noted above.

Student health information is shared via email, copies of health plans and/or staff meetings with grade level teachers, coaches, bus company and office staff.

Elementary/Intermediate Students ONLY: Yes_____ No_____ I would also like ALL school staff to be aware of my child's health condition via powerpoint presentation at an ALL school staff inservice.

Parent's Signature:	Date:
Physician's Signature:	Date: Revised 07/03/2012 Green

Principal's Initials: _____