

**Jefferson County Public Schools Health Services**  
**PCP Form/School Health Plan: Seizure Monitoring (Side One)**

JCPs Student ID # \_\_\_\_\_

School Year: \_\_\_\_\_

**Student Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **School:** \_\_\_\_\_

**TYPE OF SEIZURE:**

- Tonic-clonic (Grand Mal)
- Absence (Petit Mal)
- Simple Partial
- Complex Partial
- Other \_\_\_\_\_

**Does the student have a Vagus Nerve Stimulator?**  Yes  No

**IF** child has **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.**

**Will the student have Diastat at school?**  Yes  N

**IF** child has **DIASTAT**, please specify:

**DOSE:** \_\_\_\_\_ **MG PER RECTUM AND ADMINISTER AT:**

- Onset of seizure
- \_\_\_\_\_ minutes after onset of seizure
- Other: \_\_\_\_\_

**IF** child has **ORAL DISSOLVING TABLE (Clonazepam)** please specify:

**DOSE:** \_\_\_\_\_ **MG ADMINISTER AT:** \_\_\_\_\_

- Onset of seizure
- \_\_\_\_\_ minutes after onset of seizure
- Other: \_\_\_\_\_

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

**Rescue seizure medication will not be transported on the bus, EXCEPT for field trips ONLY. During the field trip the medication 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.) \_\_\_\_\_

**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 another 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, JCPs staff must ride with student unless parent and/or emergency contact accompanies them.
10. Document all seizure activity on the JCPs Health Services Log.
11. If the student requires medical treatment while on the bus, the driver will contact EMS.
12. Other: \_\_\_\_\_

Reviewed by Health Services \_\_\_\_\_

Entered by Health Services \_\_\_\_\_

School Received/Sent to Health Services & School Staff \_\_\_\_\_

Initials/Date

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Please complete both sides. This form must be signed by the parent/guardian AND health care provider.**

**Jefferson County Public Schools Health Services**  
**PCP Form/School Health Plan: Seizure Monitoring (Side Two)**

JCPs Student ID# \_\_\_\_\_

School Year: \_\_\_\_\_

**Student Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **School:** \_\_\_\_\_

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

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

\_\_\_\_\_  
**Printed Name of MD, APRN, or PA**      **Signature of MD, APRN, or PA**      **Address**      **Telephone #/Fax #**      **Date**

\*Parent/guardian hereby acknowledges that if this medication is not self-administered, it will most likely be administered by trained, unlicensed JCPs personnel. I acknowledge and agree when I authorize my child to attend a school sponsored field trip this medication and/or health service may also be administered by a licensed volunteer. By signing this form, the parent/guardian acknowledges that the Jefferson County Board of Education, 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 reaction 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 healthcare provider completing and signing this form to verify this information with JCPs and to consult with JCPs staff regarding this behalf of the school or its employees.

\_\_\_\_\_  
**Signature of Parent/Guardian**      **Telephone #**      **Date**  
**\*\*Parent/Guardian signature required only for INITIAL health form from current school year.**

\_\_\_\_\_  
**Emergency Contact**      **Telephone #**      **Relationship**

Were you charged a separate fee to have this form completed? <input type="checkbox"/> Yes <input type="checkbox"/> No
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**Please return to:** Jefferson County Public Schools, Health Services Department, LAM Building  
 4309 Bishop Lane, Louisville, KY 40218  
 Telephone # (502) 485-3387 Fax # 485-3670