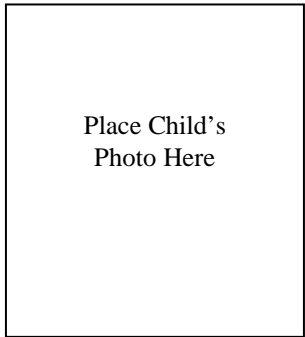


Ridgefield Public Schools

Student Seizure Information Form

Parent Form



Student's Name _____

DOB _____ Grade _____ School Year _____

Address _____

Parent's Names _____

Parent's Daytime Phone: Mother _____

Father _____

Emergency Contact # 1 Name _____ Relationship _____ Phone _____

Emergency Contact # 2 Name _____ Relationship _____ Phone _____

Emergency Contact # 3 Name _____ Relationship _____ Phone _____

Health Care Provider: _____ Phone _____

Seizure Specialist: _____ Phone _____

1. At what age did your child's seizure activity begin? _____

2. Were there any incidences prenatal, during or after birth that would have suggested cause for seizures?
 No Yes If yes, please explain. _____

3. What type of seizures does your child display? _____

Generalized which includes:

tonic-clonic (grand mal)

absence (petit mal)

myoclonic

clonic

tonic

atonic

Partial which includes:

complex partial (psycho motor/
temporal lobe)

simple partial (jacksonian/ focal
motor)

4. What kinds of behaviors are observed during a seizure? _____

5. How often do the seizures occur? _____ How long do they last? _____

6. What events might precipitate a seizure? (e.g. noise, blinking lights) _____

7. Was there any aura (visual, auditory or olfactory) present before a seizure? _____

8. Has your child ever experienced a seizure lasting longer than five minutes? Yes No If so, what intervention
 was needed? _____

9. Has your child ever been hospitalized for seizures? No Yes If yes, when _____

10. Are medications needed to control the seizures? No Yes (List below the medications taken)

Medications	Dosage	Times Given

11. Will any of these medications need to be given during school hours? No Yes If yes, name
 medication and time to be given _____

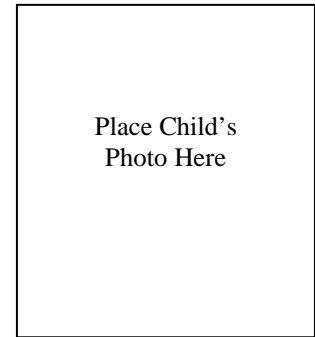
12. Does your child need any special activity adaptations or protective equipment (e. g. helmet) at school?
 No Yes Please describe. _____

13. How long after a seizure can your child return to his/her normal activity? _____

14. Would you like to speak with the school nurse? No Yes

Ridgefield Public Schools

Student Seizure Information Form Parent and Physician Form



Student Name: _____
DOB: _____ Grade: _____ School Year: _____
Address: _____
Parent's Names: _____
Parent's Daytime Phone: Parent#1: _____
Parent#2: _____
Emergency Contact # 1 Name: _____ Relationship: _____ Phone: _____
Emergency Contact # 2 Name: _____ Relationship: _____ Phone: _____
Emergency Contact # 3 Name: _____ Relationship: _____ Phone: _____
Health Care Provider: _____ Phone: _____
Seizure Specialist: _____ Phone: _____

BEHAVIORS INDICATING SEIZURE:

Action: NOTE TIME SEIZURE STARTS AND ITS DURATION

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

IF EMS is contacted: give following information in addition to contacts and health care provider information:

Additional Medical Conditions: _____

Daily Medications: _____

FOR STUDENTS WITH KNOWN SEIZURE DISORDER – EMS MUST BE CALLED FOR SEIZURES UP TO OR PAST FIVE (5) MINUTES OR SOONER IF PART OF STUDENTS SEIZURE EMERGENCY CARE PLAN.

Permission to share information with school personnel (where applicable):

Parent/Guardian____ Principal____ Guidance Dept____ Teachers____ Student____
School Nurse ____ Lunch/Recess Paras ____ Cafeteria Staff ____ Bus Company____

Parent Signature

DATE

Physician Signature

Date

Ridgefield Public Schools

Student Seizure Information Form

Student Name: _____ Grade/Teacher: _____

Does your child take/use any medication/equipment/supplies for this medical condition at home? (YES / NO)(Circle one)

If yes, please list all medications/equipment/supplies used at home:

In the event your child cannot get home due to an emergency, do you wish a supply of the listed medications/equipment/supplies be kept at school? (YES / NO) (Circle One)

(Parent to provide equipment/supplies or medication and medication authorization forms for each medication)

Signature of Parent/Guardian

Date

Nurse to complete:

Medications/Equipment/Supplies received (List):

Signature of Nurse

Date

RIDGEFIELD PUBLIC SCHOOLS

School: _____ Grade: _____

AUTHORIZATION FOR THE ADMINISTRATION OF MEDICINE BY SCHOOL PERSONNEL

Connecticut State Law 10-212a and Regulations 10-212a-1 through 10-212a-7 require a written medication order from an authorized prescriber, (physician, dentist, advanced practice registered nurse or physician's assistant) and parent/guardian written authorization, for the nurse, or in the absence of the nurse, a designated principal or teacher to administer medication, including over-the-counter drugs. Medications must be in the original properly labeled container and dispensed by a physician/pharmacist. Over-the-counter medications must be delivered in an unopened, properly labeled container.

Prescriber's Authorization

Name of Student: _____ Date of Birth: _____

Address: _____

Condition for which drug is being administered: _____

Drug Name/
Strength _____ Dose: _____ Route: _____

Time of Administration: _____ If PRN, frequency: _____

Relevant side effects: None expected Specify: _____

ALLERGIES: NO YES (specify): _____

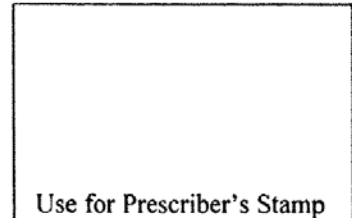
Medication shall be administered from: _____ to _____
Month / Day / Year Month / Day / Year

Prescriber's Name/Title: _____
(Type or print)

Telephone: _____ Fax: _____

Address: _____

Prescriber's Signature: _____ Date: _____



PARENT/GUARDIAN AUTHORIZATION

I hereby request that the above ordered medication be administered by school personnel and consent to communications between the school nurse and the prescriber that are necessary to ensure safe administration of this medication. I understand that I must provide the school with no more than a 90 day supply of medication. I understand that this medication will be destroyed if not picked up within one week following termination of the order or the last day of school, whichever comes first.

Parent/Guardian Signature: _____ Date: _____

Parent's Home Phone #: _____ Work #: _____

I DO / DO NOT (circle one) wish the medication BROUGHT on field trips

I DO / DO NOT wish medication ADMINISTERED on shortened days

Signature _____ Date _____

SELF-ADMINISTRATION OF MEDICATION AUTHORIZATION/APPROVAL

Self-administration of medication (inhalers, EpiPens or other medications approved by the School Medical Advisor and Head Nurse) may be authorized for middle and high school students by the prescriber and parent/guardian and must be approved by the school nurse in accordance with CT Regulations, Section 10-212a-4, and Board policy.

Prescriber's authorization for self administration: Yes No _____
Signature Date

Parent/Guardian authorization for self administration: Yes No _____
Signature Date

School nurse approval for self administration: Yes No _____
Signature Date

Received by _____ Date of Receipt/Form _____ Date of Receipt/Medication _____