Ridgefield Public Schools

Student Seizure Information Form

Parent Form

Place Child's Photo Here

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 _____

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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? _____

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5. How often do the seizures occur? _____ How long do they last? _____
6. What events might precipitate a seizure? (e.g. noise, blinking lights) _____

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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

Place Child's Photo Here

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 SERIZRE 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: _____

Use for Prescriber's Stamp

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 _____

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