



**BISHOP WATTERSON
HIGH SCHOOL**

Exemplary Catholic Education,
Rooted in Faith, Committed to Excellence

Health forms for students with **Seizures**

Please complete packet and return to the nurse at your child's school.

What is in this packet?

- 1) Seizure Questionnaire to describe student's seizure disorder
- 2) Medication Authorization - must be signed by parent and doctor and brought to school with any additional medication
- 3) Guidelines for Medicines at School – parent reference
- 4) Release of Information allows the doctor to talk to the school nurse if there are any questions.

Questions - Please call your school nurse.



Seizure Disorder Questionnaire

To be completed by parent

Student Name _____ Date of Birth _____ School Year _____
 School _____ HR / Grade _____
 Parent/Guardian _____ Phone _____
 Parent/Guardian _____ Phone _____
 Emergency Contact _____ Relationship _____ Phone _____ Healthcare
 Provider _____ Phone _____ Fax _____

*The following information will be helpful to the school nurse and school staff in determining your child's special needs.
 Questionnaire form is to be updated and completed each school year. Thank you.*

Seizure Information

Seizure Type	Length	Frequency	Description
What happens during the seizure?			
How long has your child had seizures?		What triggers the seizure?	
Are there any warning or behavior changes before the seizure? <input type="checkbox"/> yes <input type="checkbox"/> no If yes, please explain:			
How long does the seizure last?		What time of day do the seizures usually happen?	
How often do they have a seizure?		Date of their last seizure?	
How do other illnesses affect your child's seizure control?			

Medication	Dose & Time	Medication	Dose & Time

Student has a Vagus Nerve Stimulator (VMS)? yes no If yes, describe use:

Special considerations & safety precautions for school activities:
 General health Gym/ sports (physical activity) Physical functioning Learning Field trips
 Recess Bus transportation Mood / coping Behavior Other
 Explain:

What happens when your child misses a dose of seizure medication?

Are there any other recurring or chronic health problems?

Any other information that would be helpful for the teacher or nurse to know?

I authorize Bishop Watterson Staff to communicate with my child's teachers, principal/administration, school nurse and other school personnel about the seizures.

Parent's signature: _____ **Date:** _____



Medication Authorization

ONE FORM PER MEDICATION

Student Name _____ Date of Birth _____ School Year _____

Home Address _____ School _____ HR/Grade _____

If multiple medications are needed at school, please contact your school nurse for the appropriate forms

Healthcare Provider to Complete:

Bishop Watterson High School urges scheduling doses for times outside of school.

I verify the above student should receive this medication at school for treatment of _____

Medication _____ Strength/Concentration _____ Dosage _____ Route _____

Administration Time(s) _____ OR Every _____ hours as needed for _____

Beginning Date _____ Expiration Date _____ or End of school year _____

Instructions: _____

Precautions and possible side effects _____

Other medications prescribed to this student (home & school) _____

Healthcare Provider Signature _____ **Date** _____

Provider Name _____

Practice Address _____

Phone _____ Fax _____

Please fill contact information to left or stamp here

Parent to Complete:

To the Parent or Guardian: The following information is necessary for any student who uses medication in school.

- **Both the parent and healthcare provider portions of this form must be completed.**
- A new Medication Authorization form is required each school year and when there is a change in the medication.
- I authorize the student named above to receive the medication as ordered above.
- I understand the medication must not be expired, be in the original container and labeled with student's name, date, prescriber's name, name of medication, dosage, strength, route and time of administration and drug expiration date.
- I assume responsibility for the safe delivery of the medication to school and will notify the school immediately with any medication changes.
- I authorize Diocese of Columbus Health Services staff to communicate with the student's healthcare provider as needed. • I release and agree to hold the Diocese of Columbus, the Board of Education, its officials, and its employees harmless from any and all liability for damages or injury resulting directly or indirectly from this authorization.

Parent/Guardian Signature _____ **Phone Number** _____ **Date** _____

PLEASE return this form to Tonya Friend, BSN, LSN, RN, School Nurse

Email: tfriend@bwhs.org Phone 614-268-8671 ext.290 Fax 614-268-0551



Guidelines for Medications at School

Students needing to take medication during school hours must follow these guidelines:

- **Provide the school nurse with a completed Medication Authorization Form signed by both the parent/guardian and the healthcare provider.**
- **Medications cannot be at school without the form and signatures of both doctor and parents. Medications cannot be held until the medication authorization form arrives.**
- **A new Medication Authorization Form is required each school year AND when there is a change in medication or dose.**
- **All medication must be in the original container in which it was dispensed by the healthcare provider or pharmacy and be labeled with the correct dose and instructions. The medication cannot be expired.**
 - The label must match what is on the Medication Authorization Form.
 - Students taking a medication at both school and home can request 2 separate labeled bottles from the pharmacy to divide the pills to have some at home and school.
 - Students using an inhaler, epinephrine pen or other emergency medications at school can request 2 prescriptions from the healthcare provider in order to have a supply at home and school.
- **Medication must be brought to school by the parent or guardian. Bus drivers cannot be responsible for medications on the bus.**

A label must be attached to the medication which includes: the student's name, name of medication, dosage, strength, route, time of administration and expiration date. Label must match the Medication Authorization Form.

- **Medications ordered three times a day or less, unless time is specified, may not need to be taken at school.** The medication should be given before school, after school and at bedtime.

All unused medication must be picked up by the parent/guardian on the last day of student attendance or it will be discarded.



AUTHORIZATION FOR RELEASE OF INFORMATION

Date:

Student Name:		Birth Date:	
School Name:		School Phone:	
Requested by: (CCS Staff)		School Fax:	

In order to release any confidential information regarding your student, Bishop Watterson High School is required by law to have your written permission as this information is protected under the Family Educational Rights and Privacy Act (FERPA). Please sign this form to indicate the agencies or individuals that Bishop Watterson High School may receive information from or release information to regarding your student. Please keep a copy for your records. This signed authorization will be valid for one year from the date of your signature. If you wish to revoke this consent, please provide written notice to your student's school. *Please indicate the name, address and phone number of the providers that BWHS may request from or send information to. Make sure to un-check any information you do NOT wish to be shared.*

OK to Request data	OK to Send data	Provider Name	Provider Address	Provider Phone

I understand the requested information below will be used by the BWHS staff for educational and health care planning and service delivery: **Please un-check any information you do NOT wish to be shared.*

<input type="checkbox"/>	Medical Information/Records	<input type="checkbox"/>	Psychological Information/Records	<input type="checkbox"/>	Immunization Records
<input type="checkbox"/>	TB Test Results/Records	<input type="checkbox"/>	Speech and/or Hearing Evaluation	<input type="checkbox"/>	School Health Records
<input type="checkbox"/>	Other information, as specified:				

I understand any release of information pertaining to substance abuse, mental health or HIV related records will be done only if needed to better meet the educational and school health needs of the student named above. This authorization includes the use and/or disclosure of information concerning HIV testing or treatment of AIDS or AIDS-related conditions, any drug or alcohol abuse, drug-related conditions, alcoholism, and/or psychiatric/psychological conditions to the above-mentioned entity. Release of alcohol and drug abuse information is protected by Federal Confidentiality Rules (42 CFR Part 2) without written consent of the person to whom it pertains or as otherwise permitted. Federal rules also restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient (52 FR 21809, June 9, 1987; 52 FR 41997, November 2, 1987).

Authorization for Redisclosure: Under federal law, BWHS may not redisclose the information identified above to any other party without prior consent.

Parent/Guardian or Adult Student Signature

Date

Printed Name of Parent/Guardian or Adult Student