GREATER NEW BEDFORD REGIONAL VOCATIONAL TECHNICAL HIGH SCHOOL

1121 Ashley Boulevard, New Bedford, MA 02745-2496
Tel. 508-998-3321 Fax 508-995-7268 www.gnbvt.edu

Preparation • Passion • Perseverance

Dear Parent/Guardian,

According to your child's health record, your child has a diagnosis of a Seizure Disorder. Attached you will find an ***Emergency Plan*** to be completed for the upcoming school year. This plan helps maintain your child's safety and assists in communication for activities including field trips, placement and extracurricular activities. Please complete and return as soon as possible for the start of the school year. This form will be kept in the school nurse's office and a copy will be provided for out of school activities.

If you have any questions please feel free to contact the nurse's office at extension 204/205. Our direct confidential fax number is 508-998-4647.

Thank you in advance for your time,

School Nurses

GREATER NEW BEDFORD REGIONAL VOCATIONAL TECHNICAL HIGH SCHOOL
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Emergency Plan – Seizure Disorder

Field Trip/Placement/Extracurricular Activity

Student's Name:	DOB:	ID#:	YOG:

This student has a diagnosis of Seizure Disorder. Signs and symptoms of a seizure may range from a staring spell to total body stiffness and jerking.

The student should use the "one foot on the floor rule" as a guide to avoid heights greater than 2 feet and he/she should be supervised when using machinery, power tools and swimming.

If the student experiences seizure activity while off school grounds:

1. **ACTIVATE 911**
2. Lower the student to the floor – place on side
3. **DO NOT** put anything in student's mouth nor restrain
4. Clear the environment of anything that student could hit against
5. Please note onset time of seizure and be prepared to describe event
6. Stay with student until help arrives
7. Contact parent/guardian
8. Contact school nurse to report incident and provide status update at (508) 998-3321 ext. 204 or 205

EMERGENCY CONTACT INFORMATION	TELEPHONE NUMBERS
Primary Contact:	Home/Cell:
Secondary Contact:	Home/Cell:
Contact:	Home/Cell:
Signature of Parent/Guardian:	**Date:**

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Medication Order

(To Be Completed By A Licensed Prescriber – Physician, Nurse Practitioner, or Others Authorized by Chapter 94)

Student's Name:	DOB:	Grade:	
Address:	City:	State:	Zip:
Name/Title of Licensed Prescriber:	Business Phone:	Emergency Phone:	
Medication:	Dosage:		
Route of Administration:	Frequency:	Time(s) of Administration:	

Please Note: Whenever possible, medications should be scheduled at times other than school hours. Over-the-Counter medications will require a written order to be administered in school.

Special Directions/Information for Administration:

Date of Order:	Discontinue Order:

Diagnosis (If not in violation of confidentiality):

Any other Medical Condition(s):

Additional Information:

1. Special side effects, contra-indications, or possible adverse reactions to be observed:
2. Other Medications being taken by the student:
3. The date of the next scheduled visit or when advised to return to the prescriber:

Consent for self-administration provided the school nurse determines it is safe and appropriate: ☐ YES ☐ NO

Signature of Licensed Prescriber:	Date:

Comments:

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Parent/Guardian Authorization for Dispensing Medication

(To Be Completed By Parent/Guardian)

Student's Name:	DOB:	Gender:	
Address:	City:	State:	Zip:
Parent/Guardian Name(s):	Home Phone:	Cell Phone:	Work Phone:
Emergency Contact (If Parent/Guardian unavailable):	Telephone:	Relationship:	

My child is currently receiving the following medications (to be completed if not in violation of confidentiality). Please list all medication the child is receiving, including those given during the school day:

My child is known to have the following allergies:

I give permission to have the school nurse/trained personnel give the following medications:

Prescribed by:	To (Child's Name):

I give permission for my child to self-administer the medication if the school nurse determines that it is safe and appropriate.
YES ☐ NO ☐

My child has my permission to self-administer his/her inhaler according to the physician's order/instructions on the day of his/her field trip.
YES ☐ NO ☐

My child has my permission to self-administer his/her daily medication according to the physician's order/instructions on the day of his/her field trip.
YES ☐ NO ☐

I give permission for the school nurse to train unlicensed school personnel to administer epinephrine (by auto-injector) to my child with a diagnosed life-threatening allergic reaction condition when the school nurse (RN) is not immediately available or on field trips. YES ☐ NO ☐

I understand that I may retrieve the medication from the school at any time and that the medication will be destroyed if it is not picked up within one week following the expiration of the order or by the last day of the school year. I also understand that the school nurse may share, with appropriate school personnel, information relative to the prescribed medication, e.g., adverse effects, as he/she determines necessary for my child's health and safety. (if you object to this, please contact the school nurse).

Signature of Parent/Guardian:	Date:	Relationship to Student: