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 **Seizure Disorder**. Attached you will find an Emergency Care Plan for the upcoming school year. This plan helps maintain your child's safety and assists with communication regarding activities including field trips, placements, and extracurricular activities. **Please complete and return the form as soon as possible prior to the start of the school year, as this form is required annually.** The form will be kept in the nurse's office, and copies may be provided for out-of-school activities as needed.

If your child requires **emergency seizure medication**, please also complete the Parent/Guardian Authorization for Dispensing Medication form and have your child's healthcare provider complete a Medication Order Form. ***Please ensure the medication order is completed on or after July 1st of the new school year.*** All emergency seizure medications (e.g., Valtoco, Diastat, Nayzilam) must be dropped off by a parent/guardian by the first day of school.

If your child plans to participate in a fall sport, all required paperwork must be submitted to the nurse's office prior to the start of the fall sports season, including tryouts. Students will not be permitted to participate in activities outside of the school building without completed paperwork and required emergency medication on file.

If you have any questions regarding this packet, please contact the nurse's office at 508-998-3321 ext. 204/205/661/791. Please note the direct fax number to the nurse's office is 508-998-4647.

Thank you,
GNBVT School Nurses

Greater New Bedford Regional Vocational Technical High School is committed to ensuring equal opportunities for all students. The school does not discriminate on the basis of race, color, national origin, genetics, ancestry, limited English proficiency, sex, disability, religion, sexual orientation, gender identity, age, homelessness, immigration status, military status or veteran status in its education programs and activities, including admission to or employment in such programs or activities.

Michael P. Watson
Superintendent-Director

Warley J. Williams
Principal

Pamela Stuart
School Business Administrator

Maciel Pais
Executive Director Operations and Technology

Erin Ptaszenski
Executive Director Student Services

Yolanda Dennis
Executive Director DEI and Compliance

Proudly Serving the Towns of Dartmouth and Fairhaven and the City of New Bedford

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.

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. 204/205/661/791

Primary Contact:	Home/Cell:
Secondary Contact:	Home/Cell:
Contact:	Home/Cell:
Signature of Parent/Guardian:	**Date:**

Revised June 2026

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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 his/her medication if the school nurse determines that it is safe and appropriate.
YES ☐ NO ☐

I give permission for the school nurse to train designated unlicensed school personnel to administer my child's medication when the school nurse (RN) is not immediately available on field trips or during extracurricular activities. 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:

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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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