CENTRAL
UNIT SCHOOL DISTRICT 301

Department of Student Services - Health Services Division Dear Parents/Guardians:

The Nursing Department of Central CUSD 301 is committed to promoting your student's ability to learn through optimal health and well-being. Our mission is to assist students in establishing successful management of health conditions and facilitating growth in independent care while maintaining safety.

Epilepsy/Seizures can affect a student's ability and performance during school. In order to promote student success, and establish an effective individual healthcare plan (IHP), district personnel work closely with students, families and healthcare provider(s). The following guidelines have been adopted by the district to comply with government mandates:

A Seizure Plan**, signed by a healthcare provider is required** then an individual healthcare plan (IHP) for school will be implemented based on the Seizure Plan. These forms are attached.

Additional forms you *may* be asked to complete include:
-- a Questionnaire: which gathers historical information about your child's condition; -- an Authorization to Release Records, to communicate & collaborate with the healthcare provider(s) -- an Authorization for a student to Self-carry seizure medication.

Forms can be found on the District website by visiting the Health Services Department webpage. To download and print forms, hover over the Health Services tab on the left side, then select Health Requirements. Scroll down to find the link to the Seizure Packet.
.
Please have necessary documents completed and call the nurse at your child's school to schedule a meeting to review documents and implement the plan.

Respectfully,

Central CUSD 301 Health Services Staff

CHS fax: 847-464-6039, CMS fax: 847-464-0233, PKMS fax: 847-717-8105, HBT fax: 847-464-6022, PV fax: 847-464-6024, CT fax: 847-717-8006, LL fax: 630-387-7912

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UNIT SCHOOL DISTRICT 301

Healthcare Provider's Seizure Plan

Name:_____D.O.B. _____Date:_____

Diagnosis _____ Seizure Type_____

Pertinent Medical Info_____

_____

Triggers/Warning signs_____

_____

Scheduled meds at home_____

_____

Other seizure treatments:_____

_____

Medication Orders for School:

These medications must be administered/available during the school day:

Medication	Dose	Route	Frequency	Side Effects

Special Instructions: _____

_____

Plan to be implemented in school setting by healthcare professionals licensed to practice in Illinois and trained seizure care aid(s).

Healthcare Provider (print): _____

Signature: _____ Date: _____

Phone: _____ Fax: _____

Please return to Central 301 Health Services: CHS fax: 847-464-6039, CMS fax: 847-464-0233, PKMS fax: 847-717-8105, HBT fax: 847-464-6022, PV fax: 847-464-6024, CT fax: 847-717-8006, LL fax: 630-387-7912

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Individual Health Plan for School Student with Seizure Disorder

Name:_____ D.O.B. _____

Grade/Teacher/Team_____ School _____

Plan in place for one year unless otherwise specified. Expires _____

Track time of seizure: onset, length, and details
Call nurse and trained care aid(s)_____
Protect from injury
Monitor breathing / Keep airway open
Gently guide to floor; turn on side & cushion head
Do not restrain
Do not put *anything* in mouth
Promote privacy / Move other students from area
Stay with person until fully conscious
Assist with transport for further evaluation
Call 911 if: difficulty breathing, injury occurs, on a bus, 2 or more, or seizure lasts over 5 minutes
or:_____
Emergency medicine:_____
Where medicine is kept?_____ Other
_____
_____
_____

Notify family:

Name Relationship Phone Number(s)

_____

_____

_____

I give permission for this plan to be in place at school and for the medications ordered to be administered by school staff. I further consent to sharing this plan with administrators, teachers, bus drivers & other school personnel who may need to know.

Parent/guardian (print):_____

(signature): _____ Date _____

Nurse (print):_____
(signature): _____ Date _____

CENTRAL
UNIT SCHOOL DISTRICT 301

Department of Student Services - Health Services Division

Authorization to Self-Carry

Seizure Medication(s)

Name of Student _____ Date of Birth: _____

School _____Grade_____ Homeroom/Teacher_____

Diagnosis_____ Medication_____

I hereby acknowledge that I am the above referenced student or the parent/legal guardian of the above referenced student and that I am primarily responsible for administering medication to said child. However, in the event that I am unable to do so, I hereby authorize Central Community Unit School District 301 to allow self carry of the lawfully prescribed seizure medication during the following: (1) while in school; (2) while at a school sponsored activity; (3) while under the supervision of school personnel; and/or (4) before or after normal school activities. I attest that the student has been instructed on and is capable of self-administering and that he/she understands the need for the medicine and to report any side effects to school staff. I further attest that the above referenced student has been instructed to report each time the medicine is used during any of the above times to staff in the building.

I further acknowledge and agree that the School District and its employees and agents are to incur no liability, except for willful and wanton conduct by any of the said parties, as a result of any injury arising from self-administration of asthma / epinephrine medication. I further acknowledge and agree that, in the absence of willful and wanton conduct on the part of the School District and its employees and agents, I waive any claims that I might have against said parties arising out of self-administration of said medication. In addition, I agree to indemnify and hold harmless the School District and its employees and agents, either jointly or severally, except claims based on willful and wanton conduct on behalf of said parties from and against any and all claims, damages, causes of action or injury incurred or resulting from self-administration of said medication.

Print Name of Parent / Guardian_____

Signature of Parent / Guardian_____ Date: _____

Print Name of Emancipated Student_____ D.O.B: _____

Signature of Emancipated Student_____ Date: _____

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