

Boone County Schools  
 School Health Services Department  
**Seizure Health Care Plan**

Plan Date: \_\_\_\_\_ School Name: \_\_\_\_\_

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Grade: \_\_\_\_\_

Seizure appearance and length	Seizure triggers or warning signs:	Response after a seizure:

Does the student have a Vagal Nerve Stimulator?  NO  YES, describe magnet use: \_\_\_\_\_

Are medications needed to control seizures?  NO  YES, please list medications below.

Medications	Dose

Basic Seizure First Aid	Seizure Emergency First Aid
<ul style="list-style-type: none"> <li>Stay calm &amp; Time the seizure</li> <li>Keep child safe</li> <li>Do NOT restrain</li> <li>Do NOT put anything in the mouth</li> </ul>	<ul style="list-style-type: none"> <li>Contact school nurse</li> <li>Administer emergency medications - <b>Only RN may administer Versed provided by parent</b></li> <li>Call 911</li> <li>Contact parent/ guardian</li> </ul>

**Special considerations, precautions, instructions:**

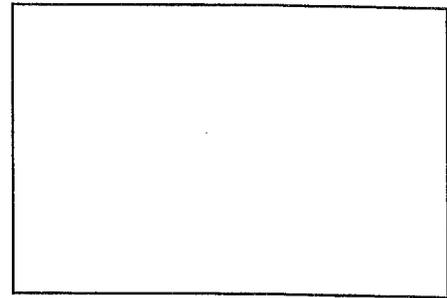
Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent Signature: \_\_\_\_\_ Phone Number: \_\_\_\_\_

School Nurse Use Only		
<input type="checkbox"/> Stable <input type="checkbox"/> Potential complications <input type="checkbox"/> High risk <input type="checkbox"/> Delegated or assigned caregiver name and date trained _____	<input type="checkbox"/> Standard seizure procedure <input type="checkbox"/> Standard school medication <input type="checkbox"/> Individual HCP	Review Date: _____  Nurse Signature: _____

**Boone County Schools  
Student Services Division  
School Health Services Department  
Transportation/Student Health Concerns**

**Photo**



**School Year:** \_\_\_\_\_

**Student Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Bus Number:** \_\_\_\_\_ **School:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_ **Age:** \_\_\_\_\_ **Grade:** \_\_\_\_\_

**Health Concern of student:** \_\_\_\_\_

Medication/supplies which will be with student during bus transportation:

\_\_\_\_\_

Is student responsible for medication administration? Yes  No

**Comments:** \_\_\_\_\_

**Emergency care to be given to student by bus driver:** \_\_\_\_\_

\_\_\_\_\_

**Parent / guardian signature:** \_\_\_\_\_

**Daytime phone number:** \_\_\_\_\_

**Date:** \_\_\_\_\_

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**This completed form must be returned to your child's school office in order for transportation to be notified.**

*School nurse is to scan completed form to Transportation: [cynthia.buttery@boone.kyschools.us](mailto:cynthia.buttery@boone.kyschools.us)*

**Boone County Schools  
School Health Services Department  
Medication Administration Consent Form**

Prescribed medications (including herbal and dietary supplements) and over the counter medications shall be given according to the instructions below. All prescription medication MUST be in the original pharmacy container, labeled with student name, prescribing healthcare provider, strength and dose of medication and directions for use, including a time(s) for dosing. Over the counter medications MUST be in their original containers. No more than one week's supply of prescription medication may be received at school; for a field trip, only the amount of medication required for the event will be accepted. Please refer to Boone County Schools medication policy and procedures for more detailed information. This consent is only valid for the current school year.

Student's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Grade: \_\_\_\_\_

Allergies: \_\_\_\_\_

**\*\*Please advise the school nurse immediately of any changes in medication or dosing.\*\***

Medication 1: _____	Diagnosis/ Condition: _____
Dose (mg/ml): _____	Route: _____ Administration time(s): _____
Possible side effects: _____	
<b>*For Epinephrine, Diastat, Glucagon or an inhaler; student has received training, is capable and:</b>	
<b>Physician's initial in appropriate box</b>	
<input type="checkbox"/> may SELF-CARRY	<input type="checkbox"/> may SELF-ADMINISTER

Medication 2: _____	Diagnosis/ Condition: _____
Dose (mg/ml): _____	Route: _____ Administration time(s): _____
Possible side effects: _____	
<b>*For Epinephrine, Diastat, Glucagon or an inhaler; student has received training, is capable and:</b>	
<b>Physician's initial in appropriate box</b>	
<input type="checkbox"/> may SELF-CARRY	<input type="checkbox"/> may SELF-ADMINISTER

**Specific to field trips:** In the case of field trips or school-related functions, slight adaptations to medication administration times may be necessary. Unless otherwise indicated, student may self-administer medication with school-trained personnel while on a field trip.

I request trained Boone County School employees to administer or supervise the administration of this medication in accordance with Boone County Schools' Medication Administration Guidelines and the above instructions. I release Boone County School District and any of its employees (hereinafter the "District") from any liability or harm which is suffered by the student (named above) as a result of this request. I further agree to indemnify and hold the District harmless from any legal action or other attempts to acquire compensation, including damages and legal and medical fees, from the District whenever the District has acted in accordance with the information provided by my child's physician.

**Trained Unlicensed School Personnel:** The Boone County Board of Education has adopted a procedure in which a staff member, from the school the child is attending, will administer either an injection, prescribed medication or other emergency procedure in the event of a crisis. The undersigned understands that the staff member administering the above care may not be a licensed healthcare professional, but that this staff member will undertake to do his or her best to comply with the procedure as developed by the student's physician in the case of a life threatening emergency where in immediate intervention is required.

Parent/ Guardian signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician name: \_\_\_\_\_ Phone number: \_\_\_\_\_

**\*\*Staff administering medication are trained annually by a registered nurse.\*\***