WEST ORANGE HIGH SCHOOL

HEALTH OFFICE

51 CONFORTI AVENUE
WEST ORANGE, NJ · 07052-2829
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DENISE MAKRI-WERZEN RN/MT(ASCP)CSN/HT, SCHOOL NURSE SONIA KELLEHER, BSN, CSN, RN, SCHOOL NURSE

School year 2011-2012

Dear Parent/Guardian of _____

Our health records indicate your child has an illness/condition that requires administration of medications during the school day. Therefore, the school policy dictates that you need to provide us with new and updated medical forms, filled out by your physician and guardians, at the beginning of each school year. **Please take note that all meds, including over the counter meds, require these forms be filled out each school year.**

MEDICAL ILLNESS/CONDITION: Please have your physician complete and sign the attached forms. Be sure to complete Step 2: Emergency Calls. We must have accurate phone numbers of those persons to be contacted in an emergency. It is imperative that these forms and meds be returned to the Nurses' Office as soon as possible.

DAILY OR AS NEEDED MEDICATION ADMINISTRATION: Please bring the medication in its original container, labeled with your child's name, physician name and phone number. Please **bring all completed medical forms and the medications to the Nurses' Office as soon as possible.**

SELF-ADMINISTRATION MEDICATON: If your child is allowed to self-administer emergency medication (i.e. Epipens, inhalers, etc) the medication must labeled with your child's name, name of medication, strength, dose, frequency, physician name with phone number and emergency contact phone numbers. If you would like to keep back up medications in our office, please bring properly labeled med containers and **completed** forms, **including *Parental Permission and Waiver* form and the *Physician Authorization for Self-Administration of Medication* form.**

The school nurses **cannot** administer any medication, or allow a student to carry medication without written authorization from you, the parent/guardian **and** the student's physician.

If at any time the information you have provided changes, including medication changes or discontinuation, you need to contact us immediately, and provide an MD note for those changes.

By the end of the school year, any medications you may have in our health office needs to be picked up by you. If the medications are not taken home, they will be discarded.

Thanking you for your cooperation and attention to this matter. Please feel free to contact us with any further questions.

Sincerely,

DENISE MAKRI-WERZEN AND SONIA KELLEHER- W.O.H.S. NURSES

SEIZURE ACTION PLAN

Effective Date_____

THIS STUDENT IS BEING TREATED FOR A SEIZURE DISORDER. THE INFORMATION BELOW SHOULD ASSIST YOU IF A SEIZURE OCCURS DURING SCHOOL HOURS.

Student's Name:_____ Date of Birth:_____

Parent/Guardian:_____ Phone: _____Cell:_____

Treating Physician:_____ Phone: _____

Significant medical history:_____

SEIZURE INFORMATION:

Seizure Type	*Length*	*Frequency*	*Description*

Seizure triggers or warning signs:_____

Student's reaction to seizure:_____

BASIC FIRST AID: CARE & COMFORT: *(Please describe basic first aid procedures)*

Does student need to leave the classroom after a seizure? YES NO
If YES, describe process for returning student to classroom

Basic Seizure First Aid:
- ✓ Stay calm & track time
- ✓ Keep child safe
- ✓ Do not restrain
- ✓ Do not put anything in mouth
- ✓ Stay with child until fully conscious
- ✓ Record seizure in log

For tonic-clonic (grand mal) seizure:
- ✓ Protect head
- ✓ Keep airway open/watch breathing
- ✓ Turn child on side

EMERGENCY RESPONSE:

A "seizure emergency" for this student is defined as:

A Seizure is generally considered an Emergency when:
- ✓ A convulsive (tonic-clonic) seizure lasts longer than 5 minutes
- ✓ Student has repeated seizures without regaining consciousness
- ✓ Student has a first time seizure
- ✓ Student is injured or has diabetes
- ✓ Student has breathing difficulties
- ✓ Student has a seizure in water

Seizure Emergency Protocol: *(Check all that apply and clarify below)*

- ☐ Contact school nurse at _____
- ☐ Call 911 for transport to _____
- ☐ Notify parent or emergency contact
- ☐ Notify doctor
- ☐ Administer emergency medications as indicated below
- ☐ Other_____

TREATMENT PROTOCOL DURING SCHOOL HOURS: (include daily and emergency medications)

Daily Medication	Dosage & Time of Day Given	Common Side Effects & Special Instructions

Emergency/Rescue Medication

Does student have a **Vagus Nerve Stimulator (VNS)**? YES NO
If YES, Describe magnet use_____

SPECIAL CONSIDERATIONS & SAFETY PRECAUTIONS: *(regarding school activities, sports, trips, etc.)*

Physician Signature:_____ **Date:**_____

Parent Signature:_____ **Date:**_____

THE PUBLIC SCHOOLS
Department of Student Support Services
West Orange, NJ 07052

To: Physicians & Parents

We are writing to ask for your cooperation as we attempt to best serve the children in our schools regarding the administration of medication during school hours.

The West Orange Public Schools' policy regarding the administration of medication during the school hours is as follows:

1) Parents & treating physicians are responsible for the diagnosis and treatment of a student's illness. The administration of prescribed medication to students during school hours will be permitted when failure to take such medicine would jeopardize the health of the student, or the student would not be able to attend school if the medicine was not available during school hours.

2) Pupils requiring medication at school must have a written statement from the family's physician that identifies the type, dosage, time schedule, purpose of the medication and possible side effects.

3) A written statement from the parent or guardian of the pupil giving permission for the school nurse to give the medication prescribed by the family physician is required.

4) Any medication to be administered during school hours must be kept in the health office.

Sincerely,

School Nurse

PARENT'S REQUEST FOR ADMINISTERING MEDICATION DURING SCHOOL HOURS

Student _____ DOB _____ Grade _____ School _____

I, the parent of _____ (student's name), request the school nurse administer the medication prescribed by _____ (Physician's Name) _____ for the period from _____ (Date) to _____ (Date).

The medication is to be furnished by me and is to be pharmacy-labeled with the name of the medicine, the amount to be given, time of day to be taken, and the expected duration of treatment. The physician's name must also be on the label. The school nurse has my permission to contact Dr. _____ at _____ (Telephone #) to the administration and effect of the medication.

_____
(Parent's signature) (Date)

PHYSICIAN'S REQUEST FOR GIVING MEDICATION AT SCHOOL

Date _____

Student's Name _____ DOB _____

To: _____, School Nurse at _____ School

Rx _____

Dosage _____

Time/special circumstances of administration _____

Period of Time _____

Purpose of Medication _____

Possible side effects _____

Physician's Name _____ Date _____

Physician Signature _____

6/05 IDG