# Pasco County Schools

Kurt S. Browning, Superintendent of Schools
7227 Land O' Lakes Boulevard • Land O' Lakes, Florida 34638


Dear Parent/Guardian:

According to District School Board of Pasco County Policy 5335, students who receive medication, health procedures or have special dietary needs (e.g. Diabetes Management, Diastat, Asthma Inhaler, EpiPen, Pancreatic Enzyme Supplement) at school shall provide **annual** parental and healthcare provider authorization for the administration of medications and procedures.

**If your child plans to carry his/her own supplies and/or perform any of the above medical procedures independently and without supervision during the next school year:**

- Please return the *Authorization to Carry and Self Administer Diabetes Medication/Procedure, Asthma Inhaler, EpiPen, Pancreatic Enzyme Supplement* form (available on the district website) signed by physician, parent and student **on or before the first day of school.**
- Please make sure your child carries all necessary supplies (Diabetes equipment or medication, Inhaler, Epipen, and/or Pancreatic enzyme supplement) at all times.

**If your child may/will require assistance with administration of medication and/or procedures at any time during the next school year:**

- Depending on your child's condition, please return either the *Severe Allergy (Anaphylaxis) or Seizure or Diabetes Medical Management Plan* form (found below) completed and signed by physician and parent **on or before the first day of school.**
- Please return the *Authorization for Medication Administration* form (available on the district website) for any medication that will need to be administered for your child **on or before the first day of school.** This form should be completed and signed by parent.
- Please provide the school clinic with all necessary supplies. Remember that medication must be brought to school by the parent / guardian (e.g. Insulin, Glucagon, Diastat, Inhaler, Epipen, etc.).

**If your child may/will require assistance with special dietary needs during the next school year:**

- Please submit completed *Diet Order Request* and/or *Severe Allergy (Anaphylaxis) Medical Management Plan* forms. The *Diet Order Request Form* will be reviewed/evaluated by the Food & Nutrition Services District Office on a case-by-case basis. Since school sites are not allergen free facilities, it may be beneficial to send a meal from home for the first few weeks of school.

While not all students' requests will be accommodated, our online menus identify common allergens and carbohydrate/nutrient information to assist you and your child in navigating their meal options. You can access this helpful tool online at https://schools.mealviewer.com/results/pasco%20county or download the mobile app on your smartphone or tablet.

Please feel free to call your child's School Nurse if you have any questions or would like to discuss your child's health status.

Thank you.

Pasco County School Health Services Program

4/2022

Seizure

# Pasco County Schools

## General Guidelines for Administration of Medication at School

1. Administration of medication during school hours should occur only when medication schedules cannot be adjusted to provide for administration at home.
2. Medication will be administered by personnel trained by the registered professional school nurse.
3. Medication must be brought to school by the parent/guardian in the original prescription container with the original prescription label containing the following information:
    a. Student's name.
    b. Name of medication (Only FDA approved [regulated] medications will be administered at school, i.e., no herbal medications, supplements, essential oils, etc.).
    c. Dosage prescribed (If the dosage changes a new prescription bottle or script must be provided).
    d. Time of day to be taken (e.g., 9:45 AM) or if the medication is ordered as needed, how many hours in between doses (e.g., every 2 hours).
    e. Physician's name.
    f. Special instructions.
    g. Date of prescription (current, within one year).
4. No more than a month's supply (30-day supply) of medications should be brought to school by a parent/guardian, at one time.
5. All medications, whether self-carry or maintained in the clinic must be entered into the Health – Clinic System Medication Order Form. Medications administered in the clinic will be recorded on the Medication Administration Record (MAR) / Medication Inventory Record (MIR) and in the Health – Clinic System. Any changes to the time or dosage requires a new MAR / MIR to be created and a discontinuation of the Medication Order Form and a new Medication Order Form will need to be created with the updated information.
6. Medication received must be counted by at least two trained staff (additional signature from parent preferred). The amount and date received is to be recorded in the Health – Clinic System and on the individual *Medication Inventory Record* form.
7. A *Parent/Guardian Permission* form must be completed by the parent/guardian, granting the school permission to assist in the administration of such medication and which shall explain the necessity for such medication to be provided during the school day, including any occasion when the student is away from school property on official school business. Parents may not need to complete this form if authorization is provided (signed by parent/guardian) via student's *Medical Management Plan*.

*Note: It is preferred that the parent/guardian of a student obtain the needed dose(s) of medication for field trips in a separate, appropriately labeled prescription container. If that is not possible, the entire bottle of medication must be sent with a trained person to be administered on the field trip. Under no circumstances may medication be transferred from one container to another by anyone other than a registered pharmacist (no medications are to be placed in envelopes or baggies).

8. FDA approved (regulated), over-the-counter medication will not be administered at school, unless accompanied by a physician's statement, dated within the current school year (exception: *Healthy Student Program*). Over-the-counter medications must be brought to school by a parent/guardian in the original, unopened container.
9. Students will be allowed to carry metered dose asthma inhalers, pancreatic enzyme supplements, epinephrine auto-injectors and/or diabetes supplies, medication, and equipment with a completed *Authorization to Carry and Self Administer* form from their parent/guardian and physician (F.S.1002.20 (3)(h), (i), (k) and/or (j)).
10. If a student is participating in an after-school activity and has emergency medication in the clinic, the registered professional school nurse and clinic assistant must be notified by the parent/student.
11. No prescription narcotic analgesics will be administered at school.
12. Parental and healthcare provider authorization for the administration of medications and treatments is required each school year.
13. All medications must be removed from the school premises one week after the expiration date, upon appropriate notification of medication being discontinued, or at the end of the school year. If not retrieved by a parent/guardian or designee, unused and unclaimed medication will be destroyed following proper disposal procedures. Legal Authority: section 1006.062, F.S.A.

*Legal Authority: section 1006.062, F.S.A.*

Pasco County Schools

# Individualized Seizure Action Plan for School Year 20_____ - 20_____

| | | | |
|---|---|---|---|
| Student's Name: _____ | Student ID: _____ | DOB: _____ | Diagnosis: _____ |
| School: _____ | | Grade: _____ | Home Room: _____ |
| Parent/Guardian #1: _____ | Home #: _____ | Cell #: _____ | Work #: _____ |
| Parent/Guardian #2: _____ | Home #: _____ | Cell #: _____ | Work #: _____ |
| Parent/Guardian's E-mail Address: _____ | | Preferred Communication Method: ☐ Phone ☐ Email | |
| Healthcare Provider: _____ | | Phone: _____ | Fax: _____ |
| | | | |

**Medical Orders (MD, PA, or ARNP who manages student's seizure disorder- complete all sections below and sign)**

## Seizure History

Date of Onset: _____ Date of Last Known Seizure: _____ Seizure Type: _____

Aura (If known): _____ Can Student Identify Aura: ☐ No ☐ Yes

Does the student understand his/her diagnosis? ☐ No ☐ Yes | Is the student able to identify oncoming seizure activity? ☐ No ☐ Yes

| | |
|---|---|
| Triggers: | ☐ Electronics (Type: _____)<br>☐ Fire Alarm/Strobe Light<br>☐ Anxiety/Startling<br>☐ Illness<br>☐ Sleep Deprivation<br>☐ Specific Time of Day/Night: _____<br>☐ Nutrional Factors: _____<br>☐ Other: _____ |

## Symptoms of Seizure

| | |
|---|---|
| ☐ Staring | ☐ Loss of Bower/Bladder Control |
| ☐ Jerking Movement of Arms and Legs | ☐ Not Responding to Noise or Words for Brief Periods |
| ☐ Stiffening of the body | ☐ Appearing Confused or in a Haze |
| ☐ Breathing difficulties | ☐ Nodding Head Rhythmically (Associated with loss of awareness or consciousness) |
| ☐ Loss of Consciousness | ☐ Having sudden rapid eye movements |
| ☐ Falling Suddenly | ☐ Other: _____ |

## Seizure Management

| | | | |
|---|---|---|---|
| Emergency Medication: _____ | Dose: _____ | Route: _____ | Administer for seizure lasting longer than _____ minutes. |
| Emergency Medication: _____ | Dose: _____ | Route: _____ | Administer for seizure lasting longer than _____ minutes. |
| Daily Medication: _____ | Dose: _____ | Route: _____ | Time of Day: _____ |

**Emergency Medication will be provided by parent:** ☐ No ☐ Yes

**Implanted Device Type:** ☐ N/A ☐ VNS | **Does the student know how to use implanted device?** ☐ No ☐ Yes

**VNS instructions (quantity of swipes and frequency):** _____

**Call 911 for the following:**

☐ If seizure continues after giving emergency medication
☐ On onset of seizure
☐ If atypical seizure activity
☐ Other: _____

**Call Parent/guardian/emergency contact for the following:** _____

**Emergency Contact:** _____

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

| Accommodations / Special Considerations: If yes please indicate accommodation(s) or restrictions needed |
|---|
| Is the student allowed to participate in sports? ☐ No ☐ Yes |
| If yes are there any restrictions? ☐ No ☐ Yes Restrictions: |
| Any restrictions/Accommodations needed for the following?<br>Classroom Setting: ☐ No ☐ Yes: _____<br>Recess: ☐ No ☐ Yes: _____<br>School Activities: ☐ No ☐ Yes: _____<br>Transportation: ☐ No ☐ Yes: _____<br>After school programming: ☐ No ☐ Yes: _____<br>Field Trips: ☐ No ☐ Yes: _____ |

| The medical professional who is completing this document shoud provide in this section additional medical orders not covered on this form: |
|---|
| |

Physician's/Mid-Level Practitioner's[1] Signature: _____ Date: _____

Place Office Stamp Here

I hereby authorize the above-named physician and Pasco County School's staff to reciprocally release verbal, written, faxed, or electronic student health information regarding the above-named child for the purpose of giving necessary medication or treatment while at school. I understand Pasco County Schools protect and secure the privacy of student health information as required by federal and state law and in all forms of records, including, but not limited to, those that are oral, written, faxed, or electronic. I hereby authorize and direct that my child's medication or treatment be administered in the manners et forth in this medical management plan. I understand that all supplies are to be furnished/restocked by parents(s)/guardian.
I acknowledge that I am the parent/guardian of the student listed above and I have the rights and authority set forth in the Parent's Bill of Rights and related laws, and I further acknowledge that I have had the opportunity to review the district's resources identifying my rights (including the notices located at https://www.pasco.k12.fl.us/ssps/page/parent_notices, and pursuant the Parent's Bill of Rights, Chap.1014, Fl. Stat.), and my acknowledgement and my consent is indicated by my signature below. I understand that the form must be completed upon entry into school and at the beginning of each school year.

Parent/Guardian Signature: _____ Date: _____

School Health Registered Nurse Signature: _____ Date: _____

[1] In accordance with 1006.0626, FL Stat., this form must be executed by a Physician or Physician Assistant (licensed under Chap. 458 or 459, FL Stat.), or an Advanced Practiced Registered Nurse (licensed under Section 464.012, FL Stat. and who provides epilepsy or seizure disorder care to the student).

**Pasco County Schools**
**Parent/Guardian Medication Administration Permission Form**

I have read Pasco County Schools' *General Guidelines for Administration of Medication at School* and permission is hereby granted to _____ Pasco County Schools'
(Name of school)
trained personnel to administer the following medication to:

_____
(Student's name) (Student #) (Grade) (DOB)

for the treatment of _____.
(Health condition)

Name of prescribing Health Care Provider: _____

Known Allergies: _____

Name of medication: _____

Dose of medication: _____ Route of medication: _____ Time to be given at school: _____

Special instructions (including reasons for which medication must be administered during the school day or at after school activities): _____

_____

Possible reactions / side effects: _____

_____

I hereby authorize designated Pasco County Schools' staff to reciprocally release verbal, written, faxed, or electronic student health information regarding the above-named child for the purpose of giving necessary medication or treatment while at school. I understand Pasco County Schools protects and secures the privacy of student health information as required by federal and state law and in all forms of records, including, but not limited to, those that are oral, written, faxed or electronic. I hereby authorize and direct that my child's medication or treatment be administered in the manner set forth in this authorization form. I understand that I am responsible to furnish/restock all supplies and medications and that any unused medication that is not retrieved by me at the end of the school year will be destroyed. I acknowledge that I am the parent/guardian of the student listed above and I have the rights and authority set forth in the Parent's Bill of Rights and related laws, and I further acknowledge that I have had the opportunity to review the district's resources identifying my rights (including the notices located at https://www.pasco.k12.fl.us/ssps/page/parent_notices, and pursuant to the Parent's Bill of Rights, Chap.1014, Fl. Stat.), and my acknowledgement and my consent is indicated by my signature below. I understand that the form must be completed each school year.

_____ Date: _____
(Signature of Parent / Guardian)

Note: Give parent copy of *General Guidelines for Administration of Medication at School*

MIS Form #791
Rev. 7/15

# DISTRICT SCHOOL BOARD OF PASCO COUNTY

7227 Land O' Lakes Boulevard
Land O' Lakes, Florida 34638

## AUTHORIZATION FOR RELEASE OF RECORDS AND/OR INFORMATION FROM RECORDS

**Please print or type:**

**RECORDS TO BE RELEASED TO** SLHS School Nurse
Contact Person

School/Agency Sunlake Highschool Phone Phone: 813-346-1000 Fax: 813-346-1090

Address 3023 Sunlake Blvd. Land O Lakes, FL 34638

**RECORDS TO BE RELEASED FROM** _____
Name of School/Agency/Person

Address _____

I, _____, do hereby authorize the release of the following

information on _____ _____ _____
Student Name Date of Birth Student #

from the above named school/agency/person:

_____Entire Cumulative Record Folder (Applicable for student transfer to another school or system)
_____Exceptional Student Education Records
_____Grades at Time of Withdrawal
_____Grading System
_____Graduation Requirements
_____Home Language Survey
_____Record of Achievements, Special Awards/Activities
_____Other Confidential Records (specify): _____

X Medical/Health Records (including speech, language, hearing, vision reports and immunization records)
_____Official School Transcript
_____Psychiatric Evaluation
_____Psychological/Social Work Reports
_____Standardized Test Scores
X Treatment/Services Plan
**Consult as needed**

### AUTHORIZATION FOR EXCHANGE OF INFORMATION/RELEASE OF CLIENT RECORDS

These records will be for the professional use of authorized District School Board of Pasco County personnel only. Records will be used for educational planning, placement, and/or evaluations. Parent permission is not required when records are requested from authorized personnel or from officials of schools/school systems in which the student seeks to enroll (Family Educational Rights and Privacy Act of 1974, FERPA). Records information shall not be released except on the condition that they will not subsequently be transferred to a THIRD PARTY without first obtaining the proper consent of the parent or eligible student.

Conditions of this exchange of information shall be in compliance with federal regulations, the Family Educational Rights and Privacy Act of 1974 (FERPA) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and all other applicable federal laws, state statutes, State Board of Education Rules, and local School Board policy.

This authorization shall be terminated one year from the date of signature unless otherwise specified. This consent may be revoked by the client/representative at any time. Revocation has no effect on action previously taken.

_____ _____
Signature of Parent/Guardian or Eligible Student Date

DISTRIBUTION: White-Referral Agency; Canary-Cumulative Folder; Pink-Originator; Goldenrod-Parent