

Form: Medical History & Physical Exam Record

Rocky Mountain School of Expeditionary Learning
1700 South Holly Street
Denver, CO 80222
303-759-2076
303-757-7442 (fax)



Student Name: _____

Student DOB: _____

Age: _____

Gender: _____

1. Instructions

Complete every item in each section. We require annual updates of the Medical History and Physical Exam Record for every student each year. Sections 6-13 must be completed and signed by the student's physician. Supplemental information forms may be required for specific health conditions, including: Asthma, Anaphylaxis, and Medications. These forms follow page 5 of this document, and require signatures of the parent and the physician.

All information will remain confidential, and you should know that many students with a variety of medical/psychological difficulties have successfully completed our expeditions. We must be aware of these conditions for the student's benefit. Failure to disclose such information could result in serious harm to the student, his/her peers, and/or staff.

2. Consent to Treat

By signing below, I/we, the parent(s)/guardian(s) of the student named below, acknowledge that I/we have signed the Permission to Participate/ Risk Acknowledgement Form for the Rocky Mountain School of Expeditionary Learning (RMSEL) fieldwork and Adventure Program. I/we understand that fieldwork and the Adventure Program can be physically and mentally demanding. On some trips, students sleep in tents, under tarps or improvised shelters. RMSEL provides suitable equipment and ample meals, but may not be able to meet special dietary requirements. Students are expected to refrain from using tobacco, alcohol, or drugs other than prescribed medication. Strenuous physical activity may include:

- | | |
|------------------------------|---|
| Walking on uneven terrain | Carrying packs up to 45 lb. |
| Immersion in cold water | Adjusting quickly to altitudes of up to 14,000 ft |
| Running | Bicycling on roads or trails |
| Horseback riding | Canoeing, kayaking or other water travel |
| Rock climbing and rappelling | Winter travel and activities |

By signing below, I/we also give consent for any emergency anesthesia, operation, hospitalization or other treatment which might become necessary. I/we understand that the experiences can be physically and mentally strenuous, occurring in a remote wilderness area, far removed from health care facilities.

I/we certify that the information provided in all parts of this form is a complete and accurate statement of the physical, medical and psychological factors which may affect this student's participation in RMSEL fieldwork. I/we realize that failure to disclose such information could result in serious harm to my/our student, other students and/or RMSEL staff. I/we agree to indemnify and hold RMSEL harmless if all relevant information is not disclosed. I/we also understand it is our responsibility to notify the RMSEL office should there be any change in the health status of the student named below.

Consent for Emergency Treatment. I/We give my/our consent for student to receive emergency medical and surgical treatment in a medical facility by a physician or other licensed health care provider should my/our student's condition require it in my/our absence. I/We further give my/our consent for any RMSEL personnel or authorized chaperone to admit my/our student to a medical facility for purposes of emergency medical and surgical treatment. I/We understand that in such a case, reasonable attempts would first be made to contact me/us at the contact information provided, time and conditions permitting. I/We further give my/our consent for any RMSEL personnel or authorized chaperone to provide basic first aid services to my/our student in the event of minor, non-life or limb threatening injury. Such authority shall include authorization to secure medical treatment for the student including the return of the student to his/her home for medical treatment.

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3. Insurance - Students must be covered by their own medical insurance.

Health and Medical Insurance. I/We represent that my/our student has no medical or health-related problems that would preclude or restrict his/her participation in the programs. I/We acknowledge that I/we have been advised to consult with a doctor if I/we have concerns about my/our student's ability to participate in RMSEL's programs. I/We acknowledge that RMSEL does not have any medical/dental/hospitalization insurance covering students for injuries incurred while participating in its programs. I/We understand that I/we am/are solely responsible for any and all costs of medical treatment required by my/our student as a result of decisions or activities relating to any element or event of RMSEL's Adventure and Fieldwork Program. I/We acknowledge that RMSEL does not assume any responsibility and has no obligation to provide financial assistance or other assistance, including medical insurance, to student in the event of injury. I/We represent that I/we have health insurance for my/our student and that I/we submitted a copy of the insurance information to RMSEL.

Is the student covered by any hospitalization and medical policy? Yes _____ No _____

A COPY OF YOUR INSURANCE CARD MUST ACCOMPANY THIS MEDICAL FORM

Please visit <https://www.allrisks.com/specialty-insurance-programs/specialty-accident-and-health-insurance/k-12-student-accident-payment/> or contact the main office if you need information about low-cost insurance coverage for your student.

4. Permission to Give Occasional Over-the-Counter-Medication Administration

SY 2026-2027 Update. in accordance with our Authorizing Physician and CDE, we will no longer be providing over-the-counter medications unless prescribed and authorized by a student's primary care provider using the *Student Medication Administration Agreement* found on page 6.

5. Parent Acknowledgement of Responsibility & Signature

I/we acknowledge that it is my/our responsibility to notify the Rocky Mountain School of Expeditionary Learning of any new diagnoses or changes to my/our student's health status, as soon as they occur, by providing an updated Medical History & Physical Exam Record, completed and signed by the physician, and that failure to do so releases the school from any liability related to such changes.

**Please provide the following pages to student's physician for completion and signature.
Form must be completed / signed by physician in order to register student.**

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7. General Health Questions Explanation

For each item answered YES in section 6, please identify the item number and answer the following:

- | | |
|---|--|
| - What specific symptoms are occurring? | - How is the symptom/condition cared for? |
| - How often do symptoms/conditions occur? | - What are the ways in which symptom/condition may restrict the student's activities in any way, including ability to run, lift, and/or climb? |
| - When did symptoms last occur? | |
| - How long do symptoms/conditions last? | |

Item #	Response to above questions:

8. Non-Anaphylactic Allergy (Anaphylaxis covered in later section)

Does the student have known non-anaphylactic allergies? YES NO

Allergy/Allergen:	Alternative/Related/Other Names

When diagnosed with this allergy?

How diagnosed with this allergy?

What are symptoms during allergic reaction?

Does the student take medication for this allergy? YES NO (if YES, a completed and signed Medication Form is required)

Additional Information:

(This section may be duplicated if additional space is needed.)

9. Dietary Restrictions

Does the student have known dietary restrictions? YES NO

To assist us in planning expedition menus, please describe any medical, religious, or ethical dietary restrictions or special needs. **If the dietary restriction involves a food allergy, please answer the questions below, and complete the ANAPHYLAXIS Form.**

Dietary Need

- | | | | |
|-----------------------------------|---|--------------------------------------|---|
| <input type="checkbox"/> Nut Free | <input type="checkbox"/> Vegetarian/Vegan | <input type="checkbox"/> Gluten Free | <input type="checkbox"/> Lactose Intolerant |
| <input type="checkbox"/> Dye Free | <input type="checkbox"/> Sugar Free | <input type="checkbox"/> Grain Free | <input type="checkbox"/> Kosher |

Describe specific food needs:

10. ADD/ADHD

Does the student have ADD/ADHD? YES NO

ADHD Inattentive Type ADHD Hyperactive Type ADHD Combined Type

When was the ADHD diagnosed?

During the last two years, has the student taken any medication for ADD/ADHD? YES NO

Is he/she currently taking any medications for ADD/ADHD? YES NO
 (if YES, a completed and signed Medication Form is required)

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10. ADD/ADHD continued
What happens if the student misses a dose?
Under the current treatment, how does the student's ADD/ADHD manifest itself?

11. Orthopedic Related Medical History	
Does the student have history of orthopedic injury/conditions?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Injury/Condition:	Date of Injury/Diagnosis:
How was the injury/condition treated?	
Does the student still have loss of function or a disability as a result of this injury/condition?	<input type="checkbox"/> YES <input type="checkbox"/> NO (if YES, a completed and signed Medication Form is required)
What description best describes the student's current condition?	<input type="checkbox"/> No longer a concern <input type="checkbox"/> Stable <input type="checkbox"/> Improving <input type="checkbox"/> Worsening
Since this injury, has the student played sports, carried a backpack, run, or hiked for regular intervals?	<input type="checkbox"/> YES <input type="checkbox"/> NO

12. If the following conditions are applicable to this student, please complete the appropriate form, located at the end of this document:			
Student has Asthma	<input type="checkbox"/> YES <input type="checkbox"/> NO	Student has Anaphylaxis <input type="checkbox"/> YES <input type="checkbox"/> NO	Student takes Medication <input type="checkbox"/> YES <input type="checkbox"/> NO

13. *Physician's Signature*****

Name of Practice, if applicable: _____

(Please Print)

Street Address _____

City, State Zip _____

Phone _____

I hereby certify that I have examined _____ and that the student has been found to be physically fit to participate in all adventure trips and activities (as described on page 1), fieldwork, and athletics activities, including: basketball, cross country, soccer, ultimate Frisbee, and/or volleyball.

The student is restricted from participating in the following activities:

Physician's Signature

Date of Exam

Physician's Printed Name

Physician's Phone Number

*****A copy of student's most recent immunization record is required with this form*****



STUDENT MEDICATION ADMINISTRATION AGREEMENT

The undersigned parent(s) or guardian(s) of:

Name of Student _____ Date of Birth ___/___/___ hereby request school staff(s) employed by the Denver Public School District to administer to said child the medication or treatment as described by the prescribing medical provider's signed instructions below.

In compliance with School District Medication Policy and Procedure and Medication Administration CDE guidance, which requires as a condition of its agreement to administer any medication, that the medicine has been prescribed by a medical provider with prescriptive authority and that it has been furnished by the parent/guardian(s) of the student with the original pharmacy container label stating the child's name, name of the medication, the dosage, the route, the number of doses per day or time(s) and the date when the medication is to be discontinued (if applicable). This applies to all medications including over-the-counter and homeopathic medications including essential oils. It is understood that the medication is given solely at the request of and as an accommodation to the undersigned parent/guardian(s). The undersigned parent/guardian(s) hereby agree(s) to release the Denver Public Schools and its school staff from any and all claim(s) which they now have or may hereafter have to arise out of the administration of, or failure to administer, the medication to the student.

By signing, the parent/guardian agrees that Denver Public Schools Staff, including the Nursing & Student Health Services Director and/or designee, and the school nurse at the student's school, may contact outside providers for further information about the student's medical needs. It is also agreed that the outside provider is granted permission to release confidential information to DPS staff. It is understood that this information will be kept confidential, and will be used only for the purpose of making a decision about the relevance of the Medical Accommodation Plan to the educational needs of the student.

*PLEASE NOTE: For medication to be given at home and school, please ask the pharmacist for a separate, accurately labeled medication bottle to be kept at school.

*BE ADVISED: It is the Parents'/Guardians' responsibility to pick up student medication by student dismissal on the last day of school. Medications left unclaimed will be disposed of according to the Colorado Department of Public Health and Environment (CDPHE) Medical and Pharmaceutical Waste Guidance.

Signature of Parent or Guardian

Month/Day/Year

MEDICAL PROVIDER SIGNED ORDER FOR MEDICATION

This form must be completed for any medication a student will need to take during school day and school related activities.

Please be aware that any medications, including samples, must have a medication label to be administered at school.

Student's Name: _____ Grade: _____ Date of Birth: ___/___/___

Medication/Treatment Name (one per form) _____ Dosage: _____

Route: _____ Frequency: _____ Times given at School: _____

Starting date: ___/___/___ Ending date: ___/___/___ or until end of school year

Purpose of Medication: _____ Allergies: _____

Possible Side Effects: _____

Phone: _____ Fax: _____

(Print) Name of prescribing medical provider

Date: ___/___/___ Clinic Name: _____

Signature of prescribing medical provider

(Print) Name of School Nurse _____ Signature of School Nurse _____ Date: ___/___/___

*School Nurse Signature indicates that the medication and medication orders have been reviewed by school nurse



Self-Carry Medication Administration Contract

Student Name:	School:	School Year:
Grade:		
<p>Colorado law does allow responsible students to carry and self-administer their rescue inhaler and/or epinephrine auto-injector (C.R.S.22-1-119.5). In 2012, the law was extended to prescription medication. This law (C.R.S 22-1-119.3) allows the student to carry sufficient medication for a single day or for the duration of the event with approval of provider, parent and administrator. (CDE Medication Administration Guidelines - 2019).</p>		
<p>Students/Families:</p> <ol style="list-style-type: none"> 1. Self-carrying and administering any medication in the school setting is a privilege and must be kept in their own possession at all times in the original container. 2. At no time should any medication be shared with anyone else. <p>Failure to comply with either of these rules may result in loss of privilege to self-carry and administer. If privileges are revoked, the School Nurse will discuss with the Health Services administrative team and the decision will be communicated to parents and medical provider; and a new plan of care will be developed.</p>		
<p>Criteria to be met when self-carry and self-administering (Nurse check off boxes when reviewed with student/family):</p> <ul style="list-style-type: none"> <input type="checkbox"/> Student is self-directed and knowledgeable about their condition and medication. <input type="checkbox"/> Severity of the health condition warrants carrying and self-administration. <input type="checkbox"/> The student demonstrates the ability to self-administer medication properly. <input type="checkbox"/> Student is confirmed to be responsible and mature enough to carry medication. <input type="checkbox"/> Written authorization is obtained from the parent and medical provider. <input type="checkbox"/> Nurse is able to monitor the self-administration process and document 2x/year in Infinite Campus. <input type="checkbox"/> Nurse will check the expiration date on the medication when checking in with the student. <input type="checkbox"/> Student has a current medical provider order and parent/legal guardian signature permission to self-carry/administer. <input type="checkbox"/> Nurse notifies students' teachers about the student's condition and that the student is able to self-carry and administer their own medication. <input type="checkbox"/> Student is directed to notify the nurse/health tech anytime the medication is administered. 		
<p>Medication self-carried/administered:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Epi-pen - allergies <input type="checkbox"/> Inhaler - asthma <input type="checkbox"/> Over-the-Counter (OTC) oral pills (a few examples: Tylenol, Ibuprofen, digestive enzymes, essential oils/herbs/vitamins) <input type="checkbox"/> Prescriptive oral pills <input type="checkbox"/> Topical cream/ointment (ears/eyes) <p>Diabetes insulin or other treatments for Diabetes 1 and 2 are covered on the Diabetes orders and Individualized Student Health Care Plan.</p>		
Student Signature:		
Parent Signature:		
RN name:	RN Signature:	Date:

COLORADO ASTHMA CARE PLAN AND MEDICATION ORDER FOR SCHOOL AND CHILD CARE SETTINGS*

PARENT/GUARDIAN COMPLETE, SIGN AND DATE:

Child Name: _____ Birthdate: _____
 School: _____ Grade: _____
 Parent/Guardian Name: _____ Phone: _____

I approve this care plan and give permission for school personnel to share this information, follow this plan, administer medication and care for my child/youth, and if necessary, contact our health care provider. I assume responsibility for providing the school/program prescribed, non-expired medication and supplies (such as a spacer), and to comply with board policies, if applicable. I am aware **911 may be called if a quick relief inhaler is not at school** and my child/youth is experiencing symptoms.

Parent/Guardian Signature _____ Date _____

HEALTH CARE PROVIDER COMPLETE ALL ITEMS, SIGN AND DATE:

QUICK RELIEF MEDICATION: Albuterol Other: _____

Common side effects: heart rate, tremor Use spacer with inhaler (MDI)

Controller medication used at home: _____

TRIGGERS: Weather Illness Exercise Smoke Dust Pollen Poor Air Quality Other: _____

Life threatening allergy specify: _____

QUICK RELIEF INHALER ADMINISTRATION: With assistance or self-carry.

- Student needs supervision or assistance to use inhaler. Student will not self-carry inhaler.
- Student understands proper use of asthma medications, and in my opinion, can **self-carry** and use his/her inhaler at school independently with approval from school nurse and completion of contract.

	IF YOU SEE THIS:	DO THIS:
GREEN ZONE: No Symptoms Pretreat	<ul style="list-style-type: none"> • No current symptoms • Strenuous activity planned 	<p>PRETREATMENT FOR STRENUOUS ACTIVITY, please choose ONE:</p> <p><input type="checkbox"/> Not required OR <input type="checkbox"/> Student/Parent request OR <input type="checkbox"/> Routinely</p> <p>Give QUICK RELIEF MED 10-15 minutes before activity: <input type="checkbox"/> 2 puffs <input type="checkbox"/> 4 puffs</p> <p>Repeat in 4 hours, if needed for additional physical activity.</p> <p><i>If child is currently experiencing symptoms, follow YELLOW or RED ZONE.</i></p>
YELLOW ZONE: Mild symptoms	<ul style="list-style-type: none"> • Trouble breathing • Wheezing • Frequent cough • Chest tightness • Not able to do activities 	<ol style="list-style-type: none"> 1. Give QUICK RELIEF MED: <input type="checkbox"/> 2 puffs <input type="checkbox"/> 4 puffs 2. Stay with child/youth and maintain sitting position. 3. REPEAT QUICK RELIEF MED if not improving in 15 minutes: <input type="checkbox"/> 2 puffs <input type="checkbox"/> 4 puffs <p><i>If symptoms do not improve or worsen, follow RED ZONE.</i></p> <ol style="list-style-type: none"> 4. Child/youth may go back to normal activities, once symptoms are relieved. 5. Notify parents/guardians and school nurse.
RED ZONE: EMERGENCY Severe Symptoms	<ul style="list-style-type: none"> • Coughs constantly • Struggles to breathe • Trouble talking (only speaks 3-5 words) • Skin of chest and/or neck pull in with breathing • Lips/fingernails gray/blue 	<ol style="list-style-type: none"> 1. Give QUICK RELIEF MED: <input type="checkbox"/> 2 puffs <input type="checkbox"/> 4 puffs <p><i>Refer to the anaphylaxis care plan if the student has a life threatening allergy. If there is no anaphylaxis care plan follow emergency guidelines for anaphylaxis.</i></p> <ol style="list-style-type: none"> 2. Call 911 and inform EMS the reason for the call. 3. REPEAT QUICK RELIEF MED if not improving: <input type="checkbox"/> 2 puffs <input type="checkbox"/> 4 puffs <p>Can repeat every 5-15 minutes until EMS arrives.</p> <ol style="list-style-type: none"> 4. Stay with child/youth. Remain calm, encouraging slower, deeper breaths. 5. Notify parents/guardians and school nurse.

Health Care Provider Signature _____ Print Provider Name _____ Date _____
 Good for 12 months unless specified otherwise in district policy.

Fax _____ Phone _____ Email _____

School Nurse/CCHC Signature _____ Date _____
 Self-carry contract on file. Anaphylaxis plan on file for life threatening allergy to:

*Including reactive airways, exercise-induced bronchospasm, twitchy airways.



Colorado Allergy and Anaphylaxis Emergency Care Plan and Medication Orders

Student's Name: _____ D.O.B. _____ Grade: _____

School: _____ Teacher: _____



ALLERGY TO: _____

HISTORY: _____

Asthma: YES (higher risk for severe reaction) – refer to their asthma care plan
 NO

◇ STEP 1: TREATMENT ◇

SEVERE SYMPTOMS: Any of the following:

- LUNG: Short of breath, wheeze, repetitive cough
- THROAT: Tight, hoarse, trouble breathing/swallowing
- MOUTH: Swelling of the tongue and/or lips
- HEART: Pale, blue, faint, weak pulse, dizzy
- SKIN: Many hives over body, widespread redness
- GUT: Vomiting or diarrhea (if severe or combined with other symptoms)
- OTHER: Feeling something bad is about to happen, Confusion, agitation



1. INJECT EPINEPHRINE IMMEDIATELY

2. Call 911
 - Ask for ambulance with epinephrine
 - Tell EMS when epinephrine was given
3. Stay with child and
 - Call parent/guardian and school nurse
 - If symptoms don't improve or worsen give second dose of epi if available as instructed below
 - Monitor student; keep them lying down. If vomiting or difficulty breathing, put student on side

Give other medicine, if prescribed. (see below for orders) Do not use other medicine in place of epinephrine. **USE EPINEPHRINE**

MILD SYMPTOMS ONLY:

- NOSE: Itchy, runny nose, sneezing
- SKIN: A few hives, mild itch
- GUT: Mild nausea/discomfort



1. Stay with child and

- Alert parent and school nurse
- Give antihistamine (if prescribed)

2. If two or more mild symptoms present or symptoms progress **GIVE EPINEPHRINE** and follow directions in above box

DOSAGE: Epinephrine: inject intramuscularly using auto injector (check one): **0.3 mg** **0.15 mg**

If symptoms do not improve ___ minutes or more, or symptoms return, 2nd dose of epinephrine should be given if available

Antihistamine: (brand and dose) _____

Asthma Rescue Inhaler (brand and dose) _____

Student has been instructed and is capable of carrying and self-administering own medication. Yes No

Provider (print) _____ Phone Number: _____

Provider's Signature: _____ Date: _____

◇ STEP 2: EMERGENCY CALLS ◇

1. If epinephrine given, **call 911**. State that an anaphylactic reaction has been treated and additional epinephrine, oxygen, or other medications may be needed.
2. Parent: _____ Phone Number: _____
3. Emergency contacts: Name/Relationship Phone Number(s)
 - a. _____ 1) _____ 2) _____
 - b. _____ 1) _____ 2) _____

DO NOT HESITATE TO ADMINISTER EMERGENCY MEDICATIONS

I give permission for school personnel to share this information, follow this plan, administer medication and care for my child and, if necessary, contact our health care provider. I assume full responsibility for providing the school with prescribed medication and delivery/monitoring devices and release the school and personnel from any liability in compliance with their Board of Education policies.

Parent/Guardian's Signature: _____ Date: _____

School Nurse: _____ Date: _____

To be completed by healthcare provider

Student Name: _____ DOB: _____

Staff trained and delegated to administer emergency medications in this plan:

1. _____

Room _____

2. _____

Room _____

3. _____

Room _____

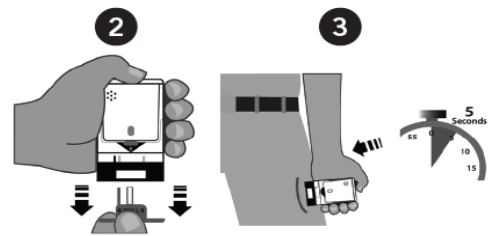
Self-carry contract on file: Yes No

Expiration date of epinephrine auto injector: _____

Keep the child lying on their back. If the child vomits or has trouble breathing, place child on his/her side.

AUVI-Q™ (EPINEPHRINE INJECTION, USP) DIRECTIONS

1. Remove the outer case of Auvi-Q. This will automatically activate the voice instructions.
2. Pull off red safety guard.
3. Place black end against mid-outer thigh.
4. Press firmly and hold for 5 seconds.
5. Remove from thigh.



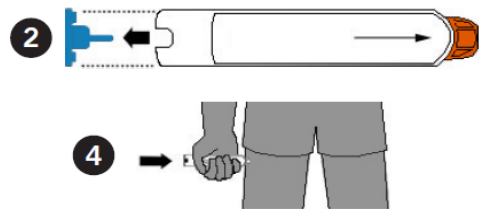
ADRENACLICK® (EPINEPHRINE INJECTION, USP) AUTO-INJECTOR DIRECTIONS

1. Remove the outer case.
2. Remove grey caps labeled "1" and "2".
3. Place red rounded tip against mid-outer thigh.
4. Press down hard until needle enters thigh.
5. Hold in place for 10 seconds. Remove from thigh.



EPIPEN® AUTO-INJECTOR DIRECTIONS

1. Remove the EpiPen Auto-Injector from the clear carrier tube.
2. Remove the blue safety release by pulling straight up without bending or twisting it.
3. Swing and firmly push orange tip against mid-outer thigh until it 'clicks'.
4. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
5. Remove auto-injector from the thigh and massage the injection area for 10 seconds.



If this conditions warrents meal accomodations from food service, please complete the form for dietary disability if required by district policy.

Additional information: _____

Adopted from the Allergy and Anaphylaxis Emergency Plan provided by the American Academy of Pediatrics, 2017

Seizure Emergency Care Plan and Medication Orders for School and Childcare Settings

PARENT/GUARDIAN complete and sign the top portion of form.		Place child's photo here
Child Name:	Birth date:	
Parent/Guardian Contact:	Phone:	
Emergency Contact:	Phone:	
School:	Grade:	
Triggers: <input type="checkbox"/> tiredness <input type="checkbox"/> flashing lights <input type="checkbox"/> illness <input type="checkbox"/> hunger <input type="checkbox"/> temperature <input type="checkbox"/> Other: _____ Seizure Aura (if any): _____ Seizure history: <input type="checkbox"/> Convulsive <input type="checkbox"/> Focal <input type="checkbox"/> Absence Date of last known seizure _____ Describe: _____		
Antiseizure Medication Taken at Home	Common side effects	
Other Seizure Treatments/Special Diet Therapy:		

I give permission for school personnel to share this information, follow this plan, administer medication and care for my child and, if necessary, contact our health care provider. I assume full responsibility for providing the school with prescribed medication and devices. I approve this Seizure Emergency Care Plan for my child.

_____ 504 plan
 PARENT SIGNATURE DATE SCHOOL NURSE SIGNATURE DATE IEP

HEALTH CARE PROVIDER to complete all items, SIGN and DATE completed form.

IF YOU SEE THIS:	DO THIS:
<input type="checkbox"/> Convulsive Generalized Tonic Clonic: You will see loss of consciousness. Stiffening of the body. Rhythmic jerking movements. Convulsive seizures may last 1-5 minutes. The child may have a warning (aura) before the seizure. Sleepiness and confusion may occur after the seizure.	<ol style="list-style-type: none"> 1. Time the seizure 2. Keep calm. Provide reassurance. 3. Protect head, keep airway clear, turn on side if possible. 4. Do not place anything in mouth. 5. Call 911 if student is injured or has difficulty breathing. 6. Call parent. 7. Stay with student until recovered from seizure. 8. Administer rescue treatments as marked below.
<input type="checkbox"/> Focal: These seizures may begin with an aura. They may be partly alert or unconscious. You may see lip smacking, chewing, eye blinking, or picking at clothes. These seizures usually last 1-2 minutes.	<ol style="list-style-type: none"> 1. Time the seizure 2. Gently guide child away from danger. 3. Stay with student and reassure them until recovered from seizure. 4. Do not treat staring that is stopped by a touch or a nudge. 5. Call parent. 6. Administer rescue treatments as marked below.
<input type="checkbox"/> Absence: You will see quick changes in alertness. May see eye flutter or small twitching. Usually last less than 10 seconds.	

Rescue Treatments

Child has a VNS. Child/staff may swipe with aura. Staff may swipe at onset of seizure and every 60 seconds until seizure stops. Give rescue medications below if seizure does not stop within _____ minutes.

If seizure lasts longer than ___ minutes administer:

<input type="checkbox"/> Diastat ___mg rectally	<input type="checkbox"/> Midazolam ___mg in the nose	<input type="checkbox"/> Clonazepam ___mg in the cheek
---	--	--

Multistep seizure rescue plan – Please see attached letter for details.

If cluster of ___ or more seizures in _____ min administer:

<input type="checkbox"/> Diastat ___mg rectally	<input type="checkbox"/> Midazolam ___mg in the nose	<input type="checkbox"/> Clonazepam ___mg in the cheek
---	--	--

Multistep seizure rescue plan – Please see attached letter for details.

If emergency medication is administered: Call 911 immediately or Call 911 if seizure does not stop within 5 minutes

Other:

If no emergency medication is at school and the child is experiencing seizures:
 Call family to bring medications to school or pick up child. Call EMS if seizure lasts more than ___ min

Accommodations: Always take seizure action plan and emergency medication for school activities, sports and field trips. Close adult supervision when swimming or climbing.

_____ HEALTH CARE PROVIDER SIGNATURE PRINT PROVIDER'S NAME _____ PHONE/FAX _____ DATE