Plan de acción para las crisis

Este/a estudiante está recibiendo tratamiento para un desorden convulsivo. La siguiente información le ayudará en caso que se presente una crisis durante el horario escolar.

Nombre del/de la estudiante: Fecha de nacimiento:

Padre/Madre /Guardián legal: Teléfono: Celular:

Otro contacto de emergencia: Teléfono: Celular:

Médico tratante: Teléfono:

Historia médica significativa:

Información de la crisis

Tipo de crisis	Duración	Frecuencia	Descripción

Lo que desencadena las crisis o señales de advertencia:

Reacción del estudiante después de una crisis:

Primeros auxilios básicos y manera de confortar al estudiante

Por favor describa los procedimientos a seguir para administrar primeros auxilios básicos:

¿Necesita el estudiante salir del salón después de una crisis? En caso de ser necesario, describa el proceso para regresar al estudiante al salón de clase: ❒ Sí ❒ Sí

Primeros auxilios básicos para una crisis

- Mantenga la calma y tome nota de la hora en que se inicia la convulsión
- Mantenga al niño o niña seguro y a salvo
- No lo/la sujete
- No le ponga nada en la boca
- Quédese con el niño o niña hasta que esté completamente consciente
- Registre la convulsión en el registro de crisis.

Para las convulsiones tónico-clónicas:

- Proteja la cabeza
- Mantenga abiertas las vías respiratorias/observe la respiración
- Coloque al niño o niña de costado

Respuesta ante Emergencias

Una "emergencia de crisis convulsiva" para este/a estudiante se define como:

Protocolo de emergencia de crisis convulsiva (Marque todo lo que aplique y aclare debajo)

- ❒ Contacte la enfermera escolar al _____
- ❒ Llame al 911 para su transporte a _____
- ❒ Notifique a los padres o al contacto de emergencia
- ❒ Administre los medicamentos de emergencia según se indica abajo
- ❒ Notifique al médico
- ❒ Otro_____

Una convulsión generalmente se considera una emergencia cuando:

- Las convulsiones (tónico-clónicas) duran más de 5 minutos
- El/la estudiante tiene convulsiones que se repiten antes de que la persona recupere la consciencia completamente
- El estudiante está herido o tiene diabetes
- El estudiante presenta una convulsión por primera vez
- El estudiante tiene dificultades para respirar
- El estudiante tiene una convulsión mientras esta en el agua

Protocolo de tratamiento durante el horario escolar (incluya medicamentos diarios y medicamentos de emergencia)

Medicamentos de emergencia	Medicamentos	Dosis y hora del día en que fue administrado	Efectos secundarios comunes e instrucciones especiales

¿Tiene el estudiante un estimulador del nervio vago? ❒ Sí ❒ No Si sí, describa el uso de imán:

Consideraciones y precauciones especiales (con respecto a las actividades escolares, deportes, viajes, etc.)

Describa cualquier consideración o precaución especial:

Firma del médico: _____ Fecha:_____

Firma del Padre/Madre/Guardián legal: _____ Fecha:_____

EPILEPSY FOUNDATION

Guthrie Public Schools

Parental Authorization to Administer Medicine or Assist with Application of Sunscreen

TO: _____ _____

(Administrator) (School)

I am the parent, guardian or legal custodian with legal custody of _____, a minor student attending this school.

☐ This student requires medication (not including sunscreen) at intervals during the school day. I hereby give my consent and authorize the school nurse, the principal, or _____ (an employee of the School District designated by the school nurse, the principal, and me) to administer:

☐ (name of drug) _____, a non-prescription medication which I am hereby supplying you, in accordance with my written instructions or the written instructions of a physician which are attached hereto.

☐ (name of drug) _____, a filled prescription medication which I am hereby supplying you, in accordance with the directions for the administration of the medicine listed on the label of the vial.

☐ (name of drug) _____, a filled prescription medication which I am hereby supplying you, in accordance with the written instructions of the physician prescribing the medicine, which is attached hereto.

☐ I hereby give my consent and authorize my child to self-medicate under the School District's Policy on the Administration of Medicine to Students.

☐ I desire that the school assist the student in applying sunscreen. I understand that the student may possess and self-apply sunscreen without my written authorization. I hereby give my consent and authorize the school nurse, the principal, or _____ (an employee of the School District designated by the school nurse, the principal, and me) to assist the student in applying sunscreen:

☐ sunscreen, which I am hereby supplying you, in accordance with the label directions.

☐ sunscreen, which I am hereby supplying you, in accordance with written instructions of the student's physician which I have attached.

I understand that under state law the Board of Education, the School District, or employees of the School District shall not be liable to the student or the student's parent or guardian for civil damages for any personal injuries to the student which result from acts or omissions of school employees in administering the medicine or assisting in the application of sunscreen I have hereby authorized. I understand that the School District, its agents and employees shall incur no liability for any adverse reaction or injury suffered by the student as a result of the self-administration of medication and/or using the specialized equipment.

I agree to abide by all of the terms of the School District's Policy on the Administration of Medicine to Students, a copy of which will be given to me on my request.

_____ _____

Date Signature

_____ _____

Address Parent with legal custody/guardian

Guthrie Public Schools
MEDICATION AUTHORIZATION

Student: _____ **Birthdate:** _____ **Grade:** ____ **School:** _____

Parent/Guardian: _____ **Phone:** _____ **Date:** _____

PRESCRIPTIONS TO BE COMPLETED BY PHYSICIAN/LICENSED PRESCRIBER:

- Reason for medication _____
- Name of medication _____
- Dosage _____
- Time and Route to be administered _____
- Duration (week, month, indefinite, etc.) _____
- Possible side effects _____

_____ _____ _____
Physician/Licensed Prescriber's Signature Office Phone Date

TO BE COMPLETED BY PARENT/LEGAL GUARDIAN:

I hereby request and give my permission for the above-named school to administer the medication authorized on this form to my child. I understand that I am responsible for maintaining the supply and picking up any remaining medication at the end of the school year; medication will not be sent home with students. Medication remaining after the school year has ended will be discarded utilizing proper procedure. I give my permission to the school nurse/designated employee to consult with the prescriber regarding this prescription.

_____ _____
Parent/Guardian Signature Date

COMPLETE ONLY FOR SELF-ADMINISTRATION OF ASTHMA MEDICATION, ANAPHYLAXIS MEDICATION, OR REPLACEMENT PANCREATIC ENZYMES

TO BE COMPLETED BY PHYSICIAN/LICENSED PRESCRIBER:

- This student has been instructed in the proper use of his/her medication. It is my professional opinion that this child is both capable and responsible of self-administering this medication and shall be allowed to carry this medication on his/her person. Yes ☐ No ☐

_____ _____
Physician/Licensed Prescriber's Signature Date

TO BE COMPLETED BY PARENT/LEGAL GUARDIAN:

I hereby give my consent and authorize my child to self-administer and/or self-carry his/her medication at school.
I will provide an emergency supply of this medication to be administered by school personnel, as required by State law.

_____ _____
Parent/Guardian Signature Date

I will not knowingly share my medication with another student.

_____ _____
Student Signature Date

It is Guthrie Public Schools policy that medication and sunscreen will only be administered by school staff with written authorization of the child's legal custodian and/or written instructions from the child's physician. Medication must be in the original container with proper labeling: child's name; medication name, strength, and expiration date; dosage and instructions for administration; name of licensed prescriber/physician; pharmacy name, address, and phone number. Authorization forms must be completed annually for each medication, and for any changes to dose/administration time. School staff will not administer medication or sunscreen that is not in the original container, improperly labeled, unauthorized, or expired. Medication must be brought to school by a parent/legal guardian.

Receiving Employee: _____ Date: _____