EPILEPSY FOUNDATION
Not another moment lost to seizures

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 _____

Other Emergency Contact _____ Phone _____ Cell _____

Treating Physician _____ Phone _____

Significant Medical History

Seizure Information

Seizure Type	Length	Frequency	Description

Seizure triggers or warning signs:

Student's response after a 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 seizure:

- Protect head
- Keep airway open/watch breathing
- Turn child on side

Emergency Response

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

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

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

A seizure is generally considered an emergency when:

- Convulsive (tonic-clonic) seizure lasts longer than 5 minutes
- Student has repeated seizures without regaining consciousness
- Student is injured or has diabetes
- Student has a first-time seizure
- Student has breathing difficulties
- Student has a seizure in water

Treatment Protocol During School Hours (include daily and emergency medications)

Emerg. Med. ✓	Medication	Dosage & Time of Day Given	Common Side Effects & Special Instructions

Does student have a **Vagus Nerve Stimulator?** ❒ Yes ❒ No If YES, describe magnet use:

Special Considerations and Precautions (regarding school activities, sports, trips, etc.)

Describe any special considerations or precautions:

Physician Signature _____ **Date** _____

Parent/Guardian Signature _____ **Date** _____

DPC772

Hamilton Community Schools
903 South Wayne Street Hamilton, Indiana 46742
260.488.2101

I, _____, give Hamilton Community Schools permission to release the following information concerning my child, _____, to the Indiana State Department of Health's Children and Hoosiers Immunization Registry Program (CHIRP):

[LIST ALL INFORMATION THAT WILL BE RELEASED, INCLUDING NAME, IMMUNIZATION DATA AND OTHER INFORMATION SUCH AS DATE OF BIRTH OR OTHER IDENTIFYING INFORMATION AS APPLICABLE]

Student name, Date of Birth, Parent/Guardian Names, past immunizations, history of having chickenpox and age

I understand that the information in the registry may be used to verify that my child has received proper immunizations and to inform me or my child of my child's immunization status or that an immunization is due according to recommended immunization schedules.

I understand that my child's information may be available to the immunization data registry of another state, a healthcare provider or a provider's designee, a local health department, an elementary or secondary school, a child care center, the office of Medicaid policy and planning or a contractor of the office of Medicaid policy and planning, a licensed child placing agency, and a college or university. I also understand that other entities may be added to this list through amendment to I.C. 16-38-5-3.

I hereby consent to the release of such information.

_____ _____
Signature Date

_____
Printed Name of Parent or Guardian

_____ ( )_____
Address Telephone Number

_____ _____
Child's Name Grade Level

_____
School

2014 – 2015 School Year
IN State Department of Health
School Immunization Requirements
Updated November 2013

3 to 5 years old	3 Hep B (Hepatitis B) 4 DTaP (Diphtheria, Tetanus & Pertussis) 3 Polio (Inactivated Polio) 1 MMR (Measles, Mumps, Rubella) 1 Varicella	
Kindergarten	3 Hep B 5 DTaP 4 Polio 2 MMR	2 Varicella 2 Hep A (Hepatitis A)
Grades 1 to 5	3 Hep B 5 DTaP 4 Polio 2 MMR	2 Varicella
Grades 6 to 11	3 Hep B 5 DTaP 4 Polio 2 MMR	2 Varicella 1 Tdap (Tetanus & Pertussis) 1 MCV4 (Meningococcal conjugate)
Grade 12	3 Hep B 5 DTaP 4 Polio 2 MMR	2 Varicella 1 Tdap 2 MCV4

Hep B The minimum age for the 3rd dose of Hepatitis B is 24 weeks of age.

DTaP Four doses of DTaP/DTP/DT are acceptable if 4th dose was administered on or after child's 4th birthday.

Polio Three doses of Polio are acceptable for all grade levels if the third dose was given on or after the 4th birthday and at least 6 months after the previous dose with only one type of vaccine used (all OPV or all IPV).

For students in grades kindergarten through 4th grade the final dose must be administered on or after the 4th birthday, and be administered **at least 6 months** after the previous dose.

Live Vaccines (MMR, Varicella & LAIV) Live vaccines that are not administered on the same day must be administered a minimum of 28 days apart. The second dose should be repeated if the doses are separated by less than 28 days.

Varicella Physician documentation of disease history, including month and year, is proof of immunity for children entering preschool through 6th grade. Parental report of disease history is acceptable for grades 7-12.

Tdap There is no minimum interval from the last Td dose.

MCV4 Individuals who receive dose 1 on or after their 16th birthday only need 1 dose of MCV4.

For children who have delayed immunizations, please refer to the 2014 CDC "Catch-up Immunization Schedule" to determine adequately immunizing doses. All minimum intervals and ages for each vaccination as specified per 2014 CDC guidelines must be met for a dose to be valid. A copy of these guidelines can be found at http://www.cdc.gov/vaccines/schedules/

Dear Parents, Guardians and Students,

The Indiana State Department of Health and the Indiana Department of Education have asked that school systems provide important information to parents and guardians of students about pertussis (whooping cough) and the vaccines available to prevent this serious illness.

Pertussis is a highly contagious respiratory infection caused by the bacteria *Bordetella pertussis*. Pertussis is spread by droplets created when an infected person coughs or sneezes. Infants and young children are usually vaccinated against pertussis, but the vaccine becomes less effective as children get older, and vaccinated children can become infected.

Pertussis causes severe coughing fits that can persist for weeks or months. During a coughing fit, the infected person may be short of breath. The coughing fit may be followed by vomiting and exhaustion. Young infants are at highest risk for developing complications from the disease like pneumonia, seizures, and death.

Teens and adults who received the pertussis vaccine when they were younger might have milder disease if they get sick with pertussis, but they can still spread it to others. The United States Centers for Disease Control and Prevention (CDC) recommends a pertussis vaccine (Tdap) for all 11-18 year old children. The Tdap vaccine, which protects against tetanus and diphtheria, as well as pertussis, can be given regardless of the time since receiving a regular tetanus booster (Td). CDC also recommends a dose of Tdap vaccine for all adults up to 65 years of age, and for adults 65 and older who have close contact with infants. Adults should talk to their healthcare provider about receiving a Tdap booster.

The Tdap vaccine is required for all students in grades 6 -12. Please talk with your child's healthcare provider about the Tdap vaccine. Additional resources for families to obtain information about pertussis disease include the following websites:

The Indiana State Department of Health
http://www.in.gov/isdh/files/PertussisQF2011.pdf

The Centers for Disease Control and Prevention
http://www.cdc.gov/vaccines/vpd-vac/pertussis/default.htm

Dear Parents, Guardians and Students,

Indiana State Law IC 20-30-5-18 requires that school systems provide important information to parents and guardians of all students about meningitis and the vaccines available to prevent one type of this serious illness at the beginning of each school year.

One type of meningitis is caused by a bacteria called *Neisseria meningitidis.* Infections caused by this bacteria are serious, and may lead to death. Symptoms of an infection with *Neisseria meningitidis* may include a high fever, headache, stiff neck, nausea, confusion and a rash. This disease can become severe very quickly and often leads to deafness, mental retardation, loss of arms or legs, and even death.

The bacteria can mainly be spread from person to person through the exchange of nose and throat secretions. This can occur through coughing, kissing, and sneezing. The bacteria are not spread by casual contact or by simply breathing the air where a person with meningitis has been. However, sometimes the bacteria that cause meningitis have spread to other people who have had close or prolonged contact with a patient with *Neisseria meningitidis.* People in the same household or anyone with direct contact with a patient's oral secretions (such as a boyfriend or girlfriend) would be considered at increased risk of getting the infection.

There are two vaccines (Menactra and Menveo) that can prevent most cases of meningitis caused by this bacteria in people over the age of 9 months. The United States Centers for Disease Control and Prevention (CDC) recommends vaccination against this disease for all children 11-18 years of age. CDC recommends vaccination of children with the meningococcal vaccine at 11 or 12 years old, with a booster dose at 16 years old. Children ages 9 months-10 years old who have sickle cell anemia or problems with their immune systems should also receive the vaccine.

One dose of meningococcal vaccine is required for students in grades 6 – 12. This is a legal requirement (Indiana Administrative Code 410 IAC 1-1-1). All students entering grades 6-12 need to have a record from the child's doctor indicating the vaccine was given or a record of this immunization in the state immunization registry (CHIRP) prior to the start of the school year.

Many local health departments and private healthcare providers offer this vaccine. Please contact your health care provider for specific instructions regarding your child.

Additional information about meningococcal disease can be found at:
The Indiana State Department of Health
http://www.in.gov/isdh/files/Meningococcal_QFV2_2010.pdf
The Centers for Disease Control and Prevention
http://www.cdc.gov/vaccines/vpd-vac/mening/default.htm
The Indiana Department of Education School Health Student Services
http://www.doe.in.gov/sservices/healthservices/

HEALTH SERVICES DEPARTMENT

School Entry Physical Examination

TO BE COMPLETED BY PARENT _____

Student's name *(last, first)* _____ Birth date ___/___/___

SEX: [ ] M [ ] F Street address _____ School_____ Grade_____

Parent/Guardian name _____ Home phone _____

Check health conditions below that affect your child.

[ ] ADD/ADHD	[ ] cystic fibrosis	[ ] heart condition	[ ] sickle cell anemia
[ ] allergies	[ ] diabetes	[ ] kidney disorder	[ ] visual impairment
[ ] asthma	[ ] food allergy	[ ] malignancy	[ ] other _____
[ ] bee sting allergy	[ ] G.I. disorder	[ ] neurological disorder	_____
[ ] chickenpox (date _____)	[ ] hearing loss	[ ] seizures	_____

Give a brief history of serious accidents, surgeries and/or health conditions of your child. _____

_____

_____

List medication your child is taking regularly. _____

_____

Parent/Guardian signature _____ Date _____

TO BE COMPLETED BY PHYSICIAN _____

HT _____ WT _____ Bp _____ LEAD TEST: Date___/___/___ [ ] capillary or [ ] venous Result _____

* *Lead testing only if physician deems applicable*

	NORM.	*ABNORM.*	*REMARKS*
Eyes			Vision: RT LT
ENT			
Lungs			
Heart			
Abdomen			
Hernia			
Extremities			
Neuro			
Skin			

Other conditions/disabilities: _____

Urine *(if applicable)*: Alb ____ Sugar ____ Should child be restricted from any activities? [ ] yes [ ] no If yes, explain.

_____

_____

Physician's signature _____ Date _____

HEALTH SERVICES DEPARTMENT

School Entry Dental Examination

Student's name _____ Birth date ____/____/____
(last) (first) (initial)

Street address _____

City/ZIP _____

School _____

Dentist's name _____ Dentist's phone number _____

THE FOLLOWING TO BE COMPLETED BY EXAMINING DENTIST:

1. Untreated decay in deciduous teeth	☐ yes	☐ no
2. Untreated decay in permanent teeth	☐ yes	☐ no
If yes, to 1 or 2 above, please answer a, b and c below.		
a. Decay is classified as *early childhood caries/babybottle caries* (affecting the primary maxillary anterior teeth, followed by involvement of the primary molars; mandibular incisors may not be affected)	☐ yes	☐ no
b. Decay is classified as rampant caries in permanent teeth	☐ yes	☐ no
c. Child is experiencing pain *and/or infection*	☐ yes	☐ no
3. Occlusion is within normal range for age	☐ yes	☐ no
If no, immediate follow-up is indicated	☐ yes	☐ no
4. Oral hygiene	☐ optimal	☐ needs improvement
5. This is child's first dental examination	☐ yes	☐ no
6. All necessary dental treatment completed	☐ yes	☐ no
If no, appointments are made for completing treatment	☐ yes	☐ no

COMMENTS:

Dentist's signature _____ Date _____

Revised 3/2014