Brantley County Schools

SCHOOL NURSE PARENT INFORMATION LETTER

Dear Parent/Guardian,

We need your assistance and cooperation in preparing for the possibility that your child might need to take medication, become ill or have an accident during school hours. We hope this letter will explain our procedures.

Emergency Information:
Emergency contact information should be updated annually by sending the information to the school or calling the school office. When you receive the Student Health Profile, please complete it and return it to the school within five days. If there is not a health profile on file the student can receive no treatment other than in an emergency situation. Current, accurate information will enable us to contact you whenever there is a need. If any information changes during the school year, notify the school of these changes as soon as possible.

Prescription/Non-Prescription Medication:
Medication time schedules should be set so that, when possible, medicine is taken at home rather than at school. However, if medication must be taken at school, the following procedures apply:
1. Medication Authorization Form – The parent/legal guardian must complete an authorization and instruction form titled "Authorization to Give Medication at School" (for over-the-counter & prescription medication). For *prescription* medication given more than 2 weeks, *your healthcare provider must also sign* the form. A copy of this form can be provided upon request from the school.
2. The medicine, in the original container (along with authorization form), must be taken to the school office/clinic for central storage. The parent/guardian should take the medication to school; if this is not possible, however, *arrangements can be made per school nurse/principal*. Under no circumstances should medication be shown or shared with other students.
3. At the designated time, the student will go to the office/clinic to take the medication. Assistance/supervision will be given in accordance with the instructions on the authorization form.
4. Unused medication should be retrieved from the school office/clinic within one week after medication is discontinued; otherwise the school will dispose of the medication.

StudentIllness/Injury:
Sick students who are contagious must not be sent to school. When a student becomes ill at school, the parent must arrange for the student to be taken home.

By working together, we can strive to ensure the health and well-being of every student so that he/she can benefit from the educational program.

Mary Mathie RN and Kerrie Dawson LPN
School Nurse Phone Number: 912-462-5179 (NPS)

912-462-5166 (NES)

Brantley County School Health Services
Authorization To Give OTC Medication at School
2026 - 2027

NOTE: If medication can be given at home or after school hours, please do so. However, if medication must be given during school hours, this form must be completed.

Student Name: _____ DOB: ___/___/_____ School: _____

Homeroom Teacher: _____ Grade: _____ Bus #: _____ Car Rider ☐

I hereby request that the Brantley County School District, through the principal, school nurse, or designee, supervise/assist in the administering of medication to my child according to the instructions contained in the statement below. I understand that:

- All medication MUST be in its original container, not expired, and be brought to school by the parent or guardian. Medications brought in baggies or other unmarked containers will not be accepted or administered.
- Parents/Guardians must provide: specific instructions, as well as the medication and related equipment needed.
- It is the responsibility of the parent/guardian to inform the school in writing of any changes to medications.
- Medications that allow doses to be administered before or after school should not be brought to school for school dosing. (**exception:** physician prescribes medications/treatments at a specific time during the school day)
- School personnel CANNOT give medication that contains ASPIRIN to students under 18 years of age due to the correlation with Reye's Syndrome. Examples: Pepto Bismol, Excedrin Migraine, Goody's powder.

The safety & well-being of your child is our top concern. With your understanding and cooperation, we can decrease unnecessary medication administrations and ensure required medications/treatments are received as directed during the school day. If you have any questions regarding medications, please call the school or your school nurse.

* I give the above-mentioned personnel permission to contact my child's health care provider and/or pharmacy to acquire medical information concerning my child's diagnosis, medication, and other treatment(s) required.*

Start Date	End Date	Medication Name	Medication Dosage	Time to be Given	Parent/Guardian Signature	Date

*I have read this form and I understand that school personnel will administer the medication(s) in accordance with the system's procedures. I understand my responsibility to school personnel who are assisting me in this matter of medication administration to my child while at school. I agree that the school system and personnel will not be held legally responsible or liable for any illness or damage that may result from administration or lack of administration of this medication to my child or from the storage of medication supplies for my child. I agree to provide any and all supplies and equipment necessary to carry out this request.

_____ _____ _____/_____/_____

Parent/Legal Guardian Signature **Date** **Home Phone** **Work Phone** **Cell Phone**

Brantley County School Health Services

Seizure Action Plan

2026 - 2027

☐ **Bus Rider** ____ ☐ **Car Rider**

Student Name: _____ DOB:____/____/_____ Age:_____

School: _____ Homeroom Teacher: _____ Grade: _____

Parents/Guardians Name(s): _____

Phone # _____ Phone # _____ Work Phone #: _____

OTHER Emergency contact: _____ Phone: _____ Relation: _____

Epilepsy Provider:_____ **Phone:**_____

Primary Care Provider:_____ **Phone:**_____

Hospital Preference: _____

SEIZURE INFORMATION: * Initial Diagnosis Date? _____

Seizure Type	How Long Does It Last?	How Often?	What Happens?	Date of last seizure?

SEIZURE MEDICATIONS:

DAILY MEDICATION		
Name:	Dose:	How/when administered?
*****RESCUE / EMERGENCY MEDICATION*****		
Name:	**Dose:**	**HOW & WHEN to give?******

TREATMENT ORDERS for SCHOOL:

Where is RESCUE/EMERGENCY medication kept at school?_____

TRIGGERS: _____

DEVICE: ☐**VNS** ☐**RNS** ☐**DBS** **Date implanted:** _____

Special Considerations & Precautions: ▢ **PE/Sports** ▢ **Recess** ▢ **Field Trips** _____

☐ **Diazepam RECTAL Gel: ____mg rectally as needed for:**
- ☐ Seizure > _____ minutes **OR**
- ☐ for ____ or more seizures in ____ hours

☐ **Valtoco NASAL Spray: ____mg as needed for:**
- ☐ Seizure > _____ minutes **OR**
- ☐ for ____ or more seizures in _____ hours

- **Use VNS (vagal nerve stimulator) magnet** _____
- **Other** _____
- **Call 911 if**:
  - ☐ Seizure does not stop by itself (or with VNS) within ____ minutes
  - ☐ Seizure does not stop within ____ minutes of administering diazepam (rectal or nasal)
  - ☐ Child does not start to wake up within _____ minutes after seizure is over (no diazepam given)
  - ☐ Child does not start to wake up within _____ minutes after seizure is over (after diazepam given)
- **Following a Seizure: (Please Check Off)**
  - ☐ Child should rest in nurse's office
  - ☐ Parents/Caregiver should be notified immediately
  - ☐ Child may return to class
  - ☐ Parents/Caregiver should receive a copy of the seizure record sent home with the child

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Brantley County School Health Services
Seizure Action Plan
2026 - 2027

Student's Understanding of & Ability to Manage Disorder:_____

Special Instructions (for First Responders & Emerg. Dpt.):_____

_____

Important Medical History:_____

_____

FIRST AID FOR ANY SEIZURE:

- STAY calm, keep calm, begin timing seizure
- Keep me SAFE - remove harmful objects, don't restrain, protect the head
- SIDE - turn on side if not awake, keep airway clear, don't put objects in mouth
- STAY until recovered from the seizure
- Swipe magnet for VNS
- Write down what happens
- Other: _____

WHEN TO CALL 911:

- Seizure with loss of consciousness > 5 minutes, not responding to rescue meds. if available
- Repeated seizures longer > 10 minutes, no recovery between them, not responding to rescue meds. if available
- Difficulty breathing after seizure
- Serious injury occurs or suspected, seizure in water

WHEN TO CALL YOUR PROVIDER FIRST:

- Change in seizure type, number, or pattern
- Person does not return to usual behavior (i.e., confused for a long period)
- 1st time seizure that stops on its' own
- Other medical problems or pregnancy need to be checked

▢ **If the student rides a Brantley Co. school bus, the transportation department, as well as the student's bus driver, must be notified of the student's SAP and have his/her emergency contact numbers and prescribed emergency medication available on the bus.**

Bus Driver's Name: _____ Bus #: _____

Trained by: _____ Date of Education: _____

Parent/Guardian signature indicates acknowledgement and release for sharing medical information between our student's physician and other health care providers and authorizing the designated school nurse to share medical information with other school employees as necessary.

Parent/Guardian Signature:_____ **Date:**_____

Healthcare Provider Signature:_____ **Date:**_____

Brantley County School Health Services

Student - Health Profile & Consent for School Health Services - NURSE FORM

2026 - 2027

STUDENT Demographic Information

STUDENT Name: _____ **DOB**: ____/____/_____ **Age**: _____

School: ❑ BCHS ❑ BCMS ❑ HES ❑ NES ❑ NPS ❑ AES ❑ WPS **Homeroom Teacher**: _____ **Grade**: _____

Child's Health Insurance Name: ❑ None ❑ State (Medicaid/PeachCare/Peach State/etc.) _____ ❑ Private _____

PARENT/GUARDIAN Name(s): _____ **Phone #**: _____

Phone #: _____ **E-mail Address**: _____

- **Parent/Guardian Place of Employment**: _____ **Work Phone**: _____

OTHER Emergency Contact: _____ **Phone**: _____ **Relation**: _____

OTHER Emergency Contact: _____ **Phone**: _____ **Relation**: _____

STUDENT Medical Information

Primary Provider: _____ **Specialist**: _____ **Dentist**: _____

Hospital of choice: ❑ Brunswick ❑ Waycross ❑ Jesup ❑ Other: _____

PreExisting Conditions:

Condition	Yes	Comments	Condition	Yes	Comments
Asthma or Breathing Condition			Head Injury, concussion		
AttentionDeficit/Hyperactivity Disorder			Hearing Conditions or Deafness		
Behavioral/Psych/Social Conditions			Heart Problems/Defect		
Developmental Conditions			Lead Poisoning		
Bladder Condition			Muscle Conditions		
Bleeding Condition			Seizures/Epilepsy		
Bowel Condition			Sickle Cell Disease		
Cancer			Speech Conditions		
Cerebral Palsy			Spinal Injury		
Cystic Fibrosis			Surgery(s)		
Dental Health Condition			Vision Conditions		
Diabetes: ❑Type 1 ❑Type 2			Other		
Insulin Pump					

Allergies (severe/life threatening):

Types: ❑ Plant ❑ Food ❑ Insect ❑ Medication ❑ Animal ❑ Latex ❑ Other

Name(s) of allergen(s)	Reaction	Treatment

If you checked YES to any chronic condition or severe allergy, or if there is another health condition, it is YOUR responsibility to **contact the school nurse** about having a care plan on file. Please provide details to any YES conditions or additional health conditions on the back of this form.

Medications:

(List all prescription, emergency, over-the-counter, and herbal medications your child takes regularly)

Medication Name	Dosage	Time Administered (Home/School)	Notes

Parental/Guardian Consent for School Health Services

I give my consent for the above-named child to participate in the School Health Services Program, which may include vision, hearing, height, weight, body mass index, nutrition, dental, scoliosis screenings, health appraisals, hygiene and health related issues, and nursing assessment.

I give my consent for my child to receive routine first aid administered by the school nurse or principal designee in the case of minor accidents or injury.

I give permission for the school nurse or principal designee to provide emergency care and to seek emergency medical services for my child if necessary. In

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the event that the situation is very serious, 911 will be called and the student will be transported to the nearest emergency room. Fees for transportation and medical services will be the responsibility of the parent/guardian.

Parent/Guardian Signature: _____ Date: _____

Additional Information: (MARKED HEALTH CONDITIONS / OTHER CONDITIONS)

SPECIFIC REQUESTS: regarding medication administration or care

Parent/Guardian Signature: _____ Date: _____

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SI:☐ Yes☐ No

Brantley County School Health Services
Authorization To Give PRESCRIPTION Medication at School
2026 - 2027

Student Name: _____ DOB: ___/___/_____ School: _____

Homeroom Teacher: _____ Grade: _____ Bus #: _____ Car Rider☐

I hereby request the Brantley County School District, through the principal, school nurse, or designee, supervise/assist in the administration of medication to my child according to the instructions contained in the statement below. I understand that:

- All medication MUST be: in its original, most current labeled prescription container and brought to school by the parent/guardian. (Medications brought in baggies or other unmarked containers will not be accepted or administered.)
- It is recommended that a monthly dose supply be provided for routine medications.
- Upon receipt of medication at the school, all controlled prescription medications must be counted by the parent/guardian and the school nurse (or designee) with the amount received properly documented.
- Parents/Guardians must provide: medication, specific instructions, and related equipment needed.
- It is the responsibility of the parent/guardian to inform the school in writing of any changes to medications. If the medication or treatment is changed, a new form must be completed.
- It is the parent/guardian's responsibility to keep up with providing the medication supply in a timely manner, BEFORE the student is out of medication.
- Medications that allow doses to be administered before or after school should not be brought to school for school dosing (**exception:** physician prescribes medications/treatments at a specific time during the school day).

The safety & well-being of your child is our top concern. With your understanding and cooperation, we can decrease unnecessary medication administrations and ensure required medications/treatments are received as directed during the school day. If you have any questions regarding medications, please call the school or your school nurse.

* I give the above-mentioned personnel permission to contact my child's health care provider and/or pharmacy to acquire medical information concerning my child's diagnosis, medication, and other treatment(s) required.*

NAME of Medication: _____ DOSAGE: _____

TIME to be given at school: _____ *Dosing as per Rx:* _____

Date Medication will START: _____ Date Medication will END: _____

Physician's Name: _____ Physician's Phone: _____ Fax: _____

Special Instructions: _____

Give dose(s) on: Field Trips☐ Yes☐ No
Early Release Days☐ Yes☐ No
Non-Academic/Celebration Days☐ Yes☐ No

REMIND texting Sign-up:☐ Yes☐ No
*** Text: _____ @ to 81010**

I have read this form and I understand that school personnel will administer the medication(s) in accordance with the system's procedures. I understand my responsibility to school personnel who are assisting me in this matter of medication administration to my child while at school. I agree that the school system and personnel will not be held legally responsible or liable for any illness or damage that may result from administration or lack of administration of this medication to my child or from the storage of medication supplies for my child. I agree to provide any and all supplies and equipment necessary to carry out this request.

_____ _____ _____/_____/_____

Parent/Legal Guardian Signature **Date** **Home Phone** **Work Phone** **Cell Phone**

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To be completed by the HEALTHCARE PROVIDER for all medications administered at school for greater than 2 weeks:

- **Condition/Illness Requiring Medication: _____ Diagnosis Code: _____**
- **Possible Side Effects of Medication:_____**

_____ _____

Signature of Healthcare Provider **Date**