SADDLEBACK VALLEY UNIFIED SCHOOL DISTRICT HEALTH SERVICES

VASOVAGAL SYNCOPE (FAINTING) EMERGENCY HEALTH CARE PLAN

Student: _____ DOB: _____ Grade: _____

School: _____ Teacher: _____ School Year: _____

The Student has fainted from a condition called Vasovagal syncope. This is one of the most common causes of fainting. It results from an abnormal circulatory reflex. The heart pumps more forcefully and the blood vessels relax, making it harder for blood to defeat gravity and be pumped to the brain. This temporary decrease in blood flow, the brain is deprived of oxygen and a fainting episode occurs. Examples of vasovagal syncope include fainting in scary or embarrassing situations, in a hot, crowded setting or during blood drawing, coughing, or urinating

GENERAL PRECAUTIONS:

1. The student should not stand for long periods of time. Standing can sometimes slow the speed for blood to get to the brain and back to the heart, triggering a vasovagal spell
2. The student should avoid heat which can trigger a spell
3. The student should stay hydrated, drinking adequate amounts of water throughout the day to help cool the body down.

SIGNS OR SYMPTOMS TO WATCH FOR:

- The student may be pale, hot and very sweaty, pale, or flushed.
- They may get light headed.
- They may be nauseated or have the dry heaves.

1ST AID PROCEDURES:

1. If the student is flushed, pale, or becomes sweaty or clammy, (possibly with eyes closed), have them lie down on floor in the classroom
2. Notify Parents immediately for medical follow-up.
3. If student faints help them to the ground to minimize injury. The student should lie flat on their back.
4. Elevate the legs to help restore the person's blood pressure
5. Do not move or disturb them unless they are in immediate danger from sharp objects, etc.
6. CALL 911 IF ADVISED BY PARENTS or if there is an emergency, such as the student wasn't breathing.
7. Have an emesis basin or bucket available, since an episode may cause them to vomit.
8. Have someone nearby to monitor their general condition including breathing/airway.
9. After the person recovers, encourage him or her to lie down for 15-20 minutes before attempting to get up again.
10. Document in Medical Log, noting length of time of the episode.

SADDLEBACK VALLEY UNIFIED SCHOOL DISTRICT HEALTH SERVICES
HEALTH HISTORY INFORMATION

Student: _____ **DOB:** _____ **Grade:** _____ **School:** _____

The above student has the following condition(s):

1. _____
2. _____
3. _____

Please provide us with the following information so that we may have a better understanding of your child's needs while at school.

1. Is your child under the care of a physician for the above condition(s): Yes/No
2. Has your child had a problem with this condition in the last year? Yes/No

   Physician's name: _____ ***Phone #:*** _____
3. Should your child's activities at school be restricted in any Way? (Please explain) Yes/No

   _____

   _____
4. Does your child taken medication for this condition? Yes/No

   Name of medication*:* _____ Dosage*:* _____

   Name of medication*:* _____ Dosage*:* _____

   Name of medication*:* _____ Dosage*:* _____
5. What action do you want the school to take when your child is sent to the Health Office for a problem?

   _____

   _____
6. Please list any other information that might be helpful in caring for your child.

   _____

   _____

   _____

   _____

PARENT'S AUTHORIZATION FOR EXCHANGE OF INFORMATION: I authorize the school nurse to communicate with the physician when necessary. I hereby give my permission for exchange of confidential information contained in the record of my child.

Parent Signature: _____ **Date:** _____

Reviewed by Health Services _____ **Date:** _____

SADDLEBACK VALLEY UNIFIED SCHOOL DISTRICT HEALTH SERVICES

VASOVAGAL SYNCOPE (FAINTING) EMERGENCY HEALTH CARE PLAN

Student: _____ **DOB:** _____ **Grade:** _____

EXCHANGE CONFIDENTIAL INFORMATION: (Please Initial if the following apply to your student).

1. ___ **Afterschool care:** Our child attends the afterschool daycare program "TLC" and the School District is authorized to provide them with guidelines for the treatment of our child in the event health care service is needed.
2. ___ **School Transportation:** Our child rides the school bus (other than field trips), and the School District is authorized to provide them with guidelines for the treatment of our child in the event health care service is needed.

HEALTH CARE PROVIDER/PHYSICIAN:

We grant permission for SVUSD to Exchange confidential information contained in our child's medical record with the physician noted below, and Disclose emergency health information to individuals at our child's school as needed, either as a written or verbally. We will maintain current phone numbers with the school office in case 911 is called.

***NOTE**:* One Medication Authorization form is required for each Medication needed at school.
Click on this link for an ***OCDE MEDICATION AUTHORIZATION*** to print the form, OR go to
http://www.ocde.us/Health/Documents/Medication%20Administration%20Forms/Med%20Admin%20Form%2011-15-12.pdf

PARENT CONSENT FOR HEALTH CARE AT SCHOOL

The signatures below provide authorization for the above written orders and show agreement that all procedures must be implemented in accordance with state laws and regulations. We will notify the School if there is a change in the student health status or change of physician. If changes are needed to medication, or the treatment plan, we will provide new physician's order, new written authorization or a signed addendum of this form must be provided. **This authorization is for a maximum of one year**.

We (I) understand that the District will appoint a qualified designated person(s) who will be performing the above-mentioned health care service, in accordance with California Education Code. It is our understanding that in performing this service, the designated person(s) will be using a standardized procedure that has been approved by our child's physician.

PARENT'S AUTHORIZATION

Parent Signature**:** _____ Date: _____

Health Services: _____ Date: _____

EMERGENCY CONTACT INFORMATION:

Mother: _____ Hm: _____ Cell: _____ Wk: _____

Father: _____ Hm: _____ Cell: _____ Wk: _____

Emergency Contact: _____ Hm: _____ Cell: _____ Wk: _____

Doctor: _____ Hm: _____ Cell: _____ Wk: _____