Burlington Public Schools

SEIZURE MEDICATION CONSENTS/ACTION PLAN

Student: _____ Date of Birth: _____ Weight: _____ Grade: _____ Homeroom: _____

Medical Diagnosis: _____ (Grand mal , Partial, Silent, Fever) Known Allergies: _____

Date of last known seizure: _____ Past Characteristics of Seizures: _____ Aura? ___

Order Section

*The **health care provider** must complete this section*

Diagnosis: _____Are Seizure medications prescribed for this child ? ___*Yes ___No *If yes, please list below*

Daily Medication

Medication	Dose	Route	Frequency	When to Use	Side Effects

As Needed Medication (i.e., Tylenol, Motrin, Ativan)

NOTE: *Due to State Laws a nurse cannot delegate assessment skills and/or the administration of as needed medications and/or as needed rescue medications.*

Medication	Dose	Route	Frequency	When to Use	Side Effects

Rescue Medication (i.e., diastat)

Medication	Dose	Route	Frequency	When to Use (minutes after seizure starts)	Side Effects

EMERGENCY Plan

-Help to the floor if seated or standing
-Remove objects that may cause injury, cushion head, & loosen tight clothing if applicable
*-Turn the child onto their side to keep airway clear but **do not** place anything in the mouth*
-Do not restrain/restrict movement during the seizure
-Observe the duration and characteristic of the seizure

____ **Call 911 at the onset of seizures? ___Yes____ *No *if no, then please instruct when to call_____**

____ **Call MD** (Print Name)_____ Phone # _____

Safety Orders:

Are there any activity restrictions (i.e. regarding play climbing structures)? ____ No ____*Yes *If yes, then please explain:

_____

_____

Are strobe lights a concern? ____No ____ *Yes *If yes, please explain how you want a fire drill to be handled. (i.e., Instruct child to put his head down during a fire drill, have the child carry a visor with them at all times) _____

Does the child have any known or possible triggers? ____ No ____ *Yes *If yes, please list: _____

Prescriber's Name (Please Print): _____ Phone Number: _____

Prescriber's Signature: _____ Date: _____

Must be manual, may not be rubber stamped, according to the Commonwealth of Massachusetts Board of registration in Medicine Prescribing Practices and Policy Guidelines adopted Aug. 1, 1989 and amended Dec. 12, 2001.

Parent/ Guardian _____/_____/_____/_____
(Print Name) (Home #) (Cell #) (Work #)

Parent/ Guardian _____/_____/_____/_____

Emergency Contact_____/_____/_____/_____
(Relationship to child) (Home #) (Cell #) (Work #)

Please see additional consents on the back of this form

Student: _____ Date of Birth: _____ Weight: _____ Grade: _____ Homeroom: _____

In event of field trip:

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_____ May omit (medication name or names)_____ for field trips.
(**Diastat cannot be held due to being an emergency life saving medication.)**

_____ I or my designee will be able to attend my child's field trips and assume responsibility of my child's medical & medication needs.

_____ *My child may self-administer his/her *daily medication* _____in the event of a field trip, if the child can demonstrate competency **(*Nurse must assess and evaluate "Yes" below**).

- I give the school nurse permission to share information, relative my child's seizure condition with appropriate personnel as necessary for my child's safety & health (i.e., medication side effects). ____Yes _____No

_____ _____
(Parent/Guardian's Signature ***required***) (Date)

- I give permission to the school nurse to speak with the listed doctor I provided to meet my child's health and safety needs. _____Yes _____No

_____ _____
(Parent/Guardian's Signature ***required***) (Date)

Please list all other medications the child currently takes *(please contact the school nurse if this changes any time during the school year):*_____

Please note: *All Medications must be in their original and/or pharmacy labeled containers and delivered to the nurse by a responsible adult. They may be retrieved by the parent/guardian at any time. Medications will be disposed of if they are not picked up within one week following the order's termination or at the completion of the last day of school.*

Parent/Guardian's Signature: _____ Date: _____

For Health Office Use Only

Medication:

_____Yes _____No _____Date Nurse's signature: _____

Nurse's name printed: _____

Medication storage location_____ Date Medication EXPIRES: _____