CONSENT FORM FOR ADMINISTRATION OF EMERGENCY *SEIZURE* MEDICATION

TO BE RENEWED EACH SCHOOL YEAR

(If you need assistance completing this form, contact the LIcensed School Nurse)

****Before medication can be administered by school personnel this form must be completed and on file with the school health office****

Student Name _____ Birth Date _____

School _____ Grade _____ Teacher _____ School Year _____

PHYSICIAN / LICENSED PRESCRIBER ORDER

Medication: _____ **Route:** _____

Dosing and Administration of Emergency Seizure Medication:

Administer _____ mg of medication after seizure of _____ minutes duration, or if _____ (indicate number) seizures occur within _____ (indicate period of time).

Criteria for repeat dosing: _____

Other instructions:_____

_____

Possible side effects: _____

Emergency Seizure Medication should be administered for the following type(s) of seizure(s):

☐ Generalized tonic-clonic (please describe): _____

_____

☐ Other (please describe): _____

_____

PHYSICIAN/LICENSED PRESCRIBER SIGNATURE: _____ DATE:_____

PRINT NAME:_____PHONE #:_____

CLINIC:_____FAX #: _____

PARENT/GUARDIAN AUTHORIZATION

1. I request the above medication be given to my child during regular school hours as ordered by the physician/licensed prescriber.
2. I give permission for the medication to be given by designated personnel as delegated, trained, and supervised by the Licensed School Nurse.
3. **I will provide this medication in the original, properly labeled pharmacy container.**
4. I authorize the Licensed School Nurse/designee to exchange information with my child's healthcare provider concerning any questions that arise with regard to the listed medication, medical condition, emergency plan, or side effects of this medication.
5. I authorize the Licensed School Nurse/designee to communicate with appropriate school personnel regarding this medication and emergency care plan for my child.
6. I release school personnel from any liability in relation to the administration of this medication at school.
7. I have read and understand the Medication Guidelines included with this form.

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

SCHOOL NURSE SIGNATURE:_____**Date**:_____

GUIDELINES FOR ADMINISTRATION OF EMERGENCY SEIZURE MEDICATION IN SCHOOL

The administration of medication to students shall be done only in exceptional circumstances wherein the student's health may be jeopardized without it.

1. Administration of Emergency Seizure Medication by school personnel will only be done according to the written order of a physician/licensed prescriber and written authorization of parent/guardian.
    a. Altered forms of medication will not be accepted or administered at school.
    b. Narcotics/medical cannabis will not be administered at school.
    c. Aspirin-containing products will not be administered at school.
    d. Only FDA approved treatments will be provided at school.

2. A new medication consent form is required when the medication dosage or instructions for administering the medication are changed.

3. New consent forms with appropriate signatures must be received each school year.

4. If the medication is discontinued, a physician/licensed prescriber is requested.

5. The medication should be brought to school by a parent/guardian in its original container. The following information must be on the medication container:
    a. Student's full name
    b. Name and dosage of medication
    c. Directions for administration must match the authorization form
    d. Physician/Licensed Prescriber name
    e. Date (must be current)

6. Medications are not to be carried by the student and will be kept in a locked cabinet or in the school health office unless authorized by the Licensed School Nurse. **Controlled substances must never be carried by a student.**

7. Special arrangements must be made with the Licensed School Nurse concerning administration of medication to students through gastrostomy tubes, rectal or injectable routes.