Reviewed by: _____ Date: _____

Lake Washington School District #414 Health Services

SEIZURE RESCUE MEDICATION ADMINISTRATION AUTHORIZATION AT SCHOOL

Student's Name:_____ Birthdate: _____

School: _____ Grade: _____

This section to be completed by HEALTH CARE PROVIDER

AUTHORIZATION FOR SCHOOL YEAR _____ (e.g. 2025-2026)

Diagnosis/Type of Seizure:	**Possible side effects:**
Medication:	
Strength:	**Emergency procedure in case of serious side effects:** • Call 911 • Other: _____
Dose:	
Route:	
When to administer:	
If PRN, time between doses:	
Anticipated action of medication: ☐ Stop, shorten, or prevent progression of seizure ☐ Other:_____	

LWSD Guidelines for Administration of Rescue Seizure Medication

- **911 is always called if a seizure rescue medication is administered.**
- LWSD schools do not staff a nurse on site during all school hours. In the event a nurse is not on site the medication may be administered by a non-licensed staff member who has received appropriate training and delegation from the registered nurse. If no trained staff member is on site and/or able to administer the medication, the school will call 911 and request a paramedic. Response times vary depending on location.

I request and authorize that the above-named student be administered the above-named medication in accordance with the instructions indicated. There exists a valid health reason which makes administration of the medication advisable during school hours or during such time that the student is under the supervision of school officials. Medication may be administered by non-licensed school personnel.

_____	_____	_____
Health Care Provider Signature	Printed Name	Date
_____	(_____)_____	(_____)_____
Clinic/Office	Phone Number	Fax Number

ACKNOWLEDGMENT OF PARENT OR GUARDIAN

- I authorize the school to administer the above-named medication to my student in accordance with the above order by my student's Health Care Provider.
- I understand and acknowledge it is my responsibility to provide medication in the original container and with an appropriate expiration date, and that it is my responsibility to refill this medication when it is used or expired.
- I understand and acknowledge (1) that a district RN may not be available to administer the above-named medication and that (2) this order is valid only for the current school year, which includes summer school.

_____	_____
Signature of Parent/Guardian	Date
_____	(_____)_____
Printed Name	Phone Number