



# Medication Authorization Form

Year \_\_\_\_\_

Student Name: \_\_\_\_\_ DOB: \_\_\_\_\_ School: \_\_\_\_\_ Grade: \_\_\_\_\_

**TO BE COMPLETED BY PHYSICIAN:**

**\*Diagnosis for Medication:\*** \_\_\_\_\_

Medication Name	Dose	Time To Be Given <small>*If PRN please indicate how often medication can be given*</small>	Route	Side Effects	Special Instructions <small>(Such as "take with food" or "crush pill")</small>

Start Date: \_\_\_\_\_

Stop Date: \_\_\_\_\_

If **PRN** (as needed) list symptoms /conditions under which medication is to be given: \_\_\_\_\_

\_\_\_\_\_  
Physician Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Physician Printed Name

**To be completed by parent/guardian:**

I am giving permission for my child \_\_\_\_\_ to receive the above medication/treatment at school according to school district policy and for the physician and school district staff to share information regarding my child's medication needs.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

Please turn the completed and signed form into the main office when completed.



POLICY CONCERNING ADMINISTRATION OF

MEDICATIONS/MEDICAL PROCEDURES BY SCHOOL DISTRICT PERSONNEL

HOLD HARMLESS AND INDEMNIFICATION

In consideration of the agreement of persons at the District to administer medication and/or medical procedures to \_\_\_\_\_, as requested by me and prescribed by a physician. I, on my own behalf, and on behalf of any other person associated with me, hereby agree to hold harmless and indemnify the Southgate Community School District, its Board of Education members, administrators, teachers, secretaries, and other employees, from any and all claims, damages, liabilities, demands, actions, causes of action, which may hereafter be asserted by any person, corporation, or other entity, against the parties listed above or against any other person associated with the Southgate Community School District under any legal theory based upon or arising out of circumstances related in any way to administration, by the District personnel, of medications or medical procedures to \_\_\_\_\_.

Witnesses:

\_\_\_\_\_

\_\_\_\_\_

Date

\_\_\_\_\_

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Telephone No. (Home)

\_\_\_\_\_  
Emergency Contact Name

\_\_\_\_\_  
Emergency Contact Number

# SEIZURE ACTION PLAN (SAP)



Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
Parent/Guardian: \_\_\_\_\_ Phone: \_\_\_\_\_  
Emergency Contact/Relationship \_\_\_\_\_ Phone: \_\_\_\_\_

## Seizure Information

Seizure Type	How Long It Lasts	How Often	What Happens

### Protocol for seizure during school (check all that apply)

- First aid – **Stay. Safe. Side.**
- Give rescue therapy according to SAP
- Notify parent/emergency contact
- Contact school nurse at \_\_\_\_\_
- Call 911 for transport to \_\_\_\_\_
- Other \_\_\_\_\_

### First aid for any seizure

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

### When to call 911

- Seizure with loss of consciousness longer than 5 minutes, not responding to rescue med if available
- Repeated seizures longer than 10 minutes, no recovery between them, not responding to rescue med 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)
- First time seizure that stops on its' own
- Other medical problems or pregnancy need to be checked

### When rescue therapy may be needed:

#### WHEN AND WHAT TO DO

If seizure (cluster, # or length) \_\_\_\_\_  
Name of Med/Rx \_\_\_\_\_ How much to give (dose) \_\_\_\_\_  
How to give \_\_\_\_\_

If seizure (cluster, # or length) \_\_\_\_\_  
Name of Med/Rx \_\_\_\_\_ How much to give (dose) \_\_\_\_\_  
How to give \_\_\_\_\_

If seizure (cluster, # or length) \_\_\_\_\_  
Name of Med/Rx \_\_\_\_\_ How much to give (dose) \_\_\_\_\_  
How to give \_\_\_\_\_

## Care after seizure

What type of help is needed? (describe) \_\_\_\_\_

When is student able to resume usual activity? \_\_\_\_\_

## Special instructions

First Responders: \_\_\_\_\_

Emergency Department: \_\_\_\_\_

## Daily seizure medicine

Medicine Name	Total Daily Amount	Amount of Tab/Liquid	How Taken (time of each dose and how much)

## Other information

Triggers: \_\_\_\_\_

Important Medical History \_\_\_\_\_

Allergies \_\_\_\_\_

Epilepsy Surgery (type, date, side effects) \_\_\_\_\_

Device:  VNS  RNS  DBS Date Implanted \_\_\_\_\_

Diet Therapy  Ketogenic  Low Glycemic  Modified Atkins  Other (describe) \_\_\_\_\_

Special Instructions: \_\_\_\_\_

## Health care contacts

Epilepsy Provider: \_\_\_\_\_ Phone: \_\_\_\_\_

Primary Care: \_\_\_\_\_ Phone: \_\_\_\_\_

Preferred Hospital: \_\_\_\_\_ Phone: \_\_\_\_\_

Pharmacy: \_\_\_\_\_ Phone: \_\_\_\_\_

My signature \_\_\_\_\_ Date \_\_\_\_\_

Provider signature \_\_\_\_\_ Date \_\_\_\_\_