School Year: _____

Self-Administration/Self-Possession of Medication

Self-administration means that the student can administer the medication in a manner directed by the physician without additional direction or supervision by school staff. Self-possession means that under the direction of the physician, the student may carry medication on his/her person to allow for immediate self-administration. Please complete this form if you want this student to self-administer and self-possess their medication while in school.

Student Name: _____DOB:_____ School: _____ Grade: _____

TO BE COMPLETED BY PHYSICIAN:

***Diagnosis for Medication:*_____**

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

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: ☐ self-administer ☐ self-possess the above medication according to the 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.

Updated 4/2023

School Year: _____

Student Name: _____

To be completed by student:

I agree to:

1. Never share my medication with another person
2. Carry the medication in its original properly labeled prescription or over the counter container
3. Take the medication only at the prescribed time, frequency and dose.
4. Carry a copy of this form with me and present it to the school staff if asked.

I understand if I do not comply with this agreement then the medication will be confiscated and returned to my parent/guardian and my privilege of self-administration/self- possession will be denied.

_____ _____

Student Signature Date

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

Updated 4/2023

School Year: _____

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:

_____

Signature of Parent/Guardian

_____

_____

Telephone No. (Home)

_____

_____

Emergency Contact Name

Date

_____

_____

Emergency Contact Number

Please turn completed and signed form into office when completed.

Updated 6/2019

SEIZURE ACTION PLAN (SAP)

EPILEPSY FOUNDATION | END EPILEPSY

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 _____

Epilepsy.com

Revised 01/2020 130SRP/PAB1216

EPILEPSY FOUNDATION | END EPILEPSY