Student Health Services

Seizure Treatment Order Form

Fulton County Schools
Where Students Come First

School Year: _____

Student Name: _____ **Date of Birth**: _____

Teacher: _____ Grade: _____ School: _____

Treatment/ Orders

(complete Medication Authorization Forms if medication is to be administered at school)

☐ **Diastat** (Diazepam Rectal Gel) **Dose:** ___mg as needed for seizures lasting > ___ minutes **OR** for___or more seizures in ___hour(s)

☐ **Versed** (Intranasal Midazolam) **Dose:** ___mg as needed for seizures lasting > ___ minutes **OR** for ___or more seizures in ___hour(s) (administer ½ dose per nostril)

☐ **Other Medications:** list with dosage: _____**When to administer:** _____

☐ **VNS Magnet** (Vagus Nerve Stimulator): _____ **When to use:** _____

List contraindications/ side effects of medications: _____

Other Instructions: (bus accommodations for special education students, etc.) _____

Call 911

- If seizure does not stop within _____ minutes of administer medication or using VNS
- Student shows sign of respiratory distress
- Other: _____

I am the parent/guardian of _____ and request the Seizure Treatment Order Form be utilized during school hours.

School employees will not assume any liability for supervising or assisting in the utilization of this treatment order. Completion of this Seizure Treatment Order Form authorizes Student Health Services to discuss the treatment order with the appropriate school staff and prescribing health care provider via email, fax, verbal, or written communication with the purpose of providing a safe environment for your child. I understand that I am responsible for providing the school with written orders from the Physician before the school will make any changes in procedures or medication orders if there is a change to the current order.

Physician/Health Care Provider Signature _____ Date: _____

Physician Name (print) _____ Phone # _____

Physician Address _____ Fax _____

Parent Signature _____ Date: _____

Parent Name (Print) _____ Phone # _____

Received by _____ Date: _____

Date Reviewed by Cluster Nurse/Special Education Nurse: _____

Cluster Nurse/Special Education Nurse Signature: _____

This section is to be completed by School Cluster School Nurse/Special Education Nurse/ Clinic Assistant ONLY:

Does student ride bus to and/or from school? ☐ Yes ☐ No Is an Aide on the bus? ☐ Yes ☐ No

Special Instructions for Transportation Personnel: _____

Date Received:	Medication Name:	# of Doses:
Expiration Date:	Completed by:	Dose Locked In/ Supplies Received: