

## Permission to Administer Medication

Prescription and/or non-prescription medication that must be taken by students at school requires a written request from the parent/legal guardian together with a written set of instructions from the physician who has ordered the medication. The child's name, doctor's name, name of the medicine, dosage, route, frequency or time of administration, expected duration of medication regimen, possible side effects and special instructions, shall be clearly listed by the doctor on this form. Signatures are required from both the parent/legal guardian and physician. Medication must be in the original container and labeled with child's name, doctor's name, name of the medication, dosage, route, and frequency or time of administration. Please give initial dose of any new non-emergency medication at home; monitor for side effect, reaction.

Student Name \_\_\_\_\_ Birth Date \_\_\_\_\_ School \_\_\_\_\_ Grade \_\_\_\_\_

Student Emergency Contact #1 \_\_\_\_\_ Phone Number \_\_\_\_\_

Student Emergency Contact #2 \_\_\_\_\_ Phone Number \_\_\_\_\_

Name of Attending Physician(s) \_\_\_\_\_

Physician Address \_\_\_\_\_

Physician Telephone \_\_\_\_\_ Fax \_\_\_\_\_

**MEDICATION INFORMATION (THIS SECTION SHOULD BE COMPLETED BY THE PRESCRIBING HEALTHCARE PROVIDER)**

1) Medication Name \_\_\_\_\_ Dose/Quantity \_\_\_\_\_ Route \_\_\_\_\_ Time of Administration \_\_\_\_\_

Reason for Medication \_\_\_\_\_

Adverse Reactions or Side Effects \_\_\_\_\_

\_\_\_\_\_ Start Date \_\_\_\_\_ End Date (Valid for one school year only)

2) Medication Name \_\_\_\_\_ Dose/Quantity \_\_\_\_\_ Route \_\_\_\_\_ Time of Administration \_\_\_\_\_

Reason for Medication \_\_\_\_\_

Adverse Reactions or Side Effects \_\_\_\_\_

\_\_\_\_\_ Start Date \_\_\_\_\_ End Date (Valid for one school year only)

Physician certifies this student requires the above medication during school hours.

Date \_\_\_\_\_ Physician Signature \_\_\_\_\_ (required for medication administration)

**PHYSICIAN:** If student requires an EpiPen or Inhaler, and an additional EpiPen or Inhaler is required for bus transportation or other activity, please provide an extra prescription to the parent.

**SELF-POSSESSION/SELF-ADMINISTRATION AUTHORIZATION**

**Students may possess/carry and/or self-administer medication only if authorized by the physician and parent/legal guardian.**

This student is capable of  self-carrying  self-administering:  Epinephrine  Inhaler

Physician Signature for student self-carry/administration of EpiPen/Inhaler \_\_\_\_\_ Date \_\_\_\_\_

Parent/Legal Guardian Signature for child to self-carry/administer EpiPen/Inhaler \_\_\_\_\_ Date \_\_\_\_\_

A student's authorization to possess and self-administer medication may be limited or revoked by the building principal after consultation with the school nurse and the student's parents/guardian if the student demonstrates an inability to responsibly possess and self-administer such medication. Please contact the building principal to develop a plan to address how to keep a record of administrations and when the student must seek assistance.

**PARENT/LEGAL GUARDIAN AUTHORIZATION**

I hereby request that my child be administered medication at school, by school personnel. I understand that the medication will be administered exactly as per directions of my above-named physician. I will notify the school of changes or discontinuance of this medication(s) by completing a new form. I consent and authorize the healthcare provider staff and school to share information as needed to clarify orders and assist with my child's healthcare needs. I agree that information contained herein shall be shared with individuals and staff that need to know.

Parent/Legal Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Print Parent/Legal Guardian Name \_\_\_\_\_

**NOTICE OF DISCONTINUATION OF MEDICATION ADMINISTRATION**

Please discontinue medication administration described above for my child \_\_\_\_\_ as of \_\_\_\_\_

Parent/Legal Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

# 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 \_\_\_\_\_