

Owasso Public Schools
Parent Permission To Give Short-Term Medication

Student's Name

Grade/Teacher

Date

Medication

Dose (Amount)

Time To Be Given

Other Instructions

- Medication will be dosed and administered according to directions on the box. (Any dosing needed outside of this will require a physician's order.)
- Medication will be kept in the nursing office and CAN NOT BE carried by the student at any time.

I, _____, the parent or legal guardian of _____ ("Student") request that the school nurse or designated school representative administer the above medication to my Student. I have given the first dose of Student's medication at home, if applicable. I fully release and indemnify Owasso Public School, its employees, agents, and representatives from all responsibility and liability of any side effects, adverse reactions, or any other result of administration of the medication. I also understand this agreement is only good for the current school year.

Parent's Signature

Phone 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 _____

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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 _____