PARENT CONSENT AND AUTHORIZED HEALTH-CARE PROVIDER AUTHORIZATION for Seizure Management in Educational Settings and Sponsored Events

Student:	**DOB:**	**Date:**
District/Site:	**Teacher/Rm:**	**Grade:**

Please provide the mandatory specific instructions and authorization to assist school staff in seizure management as needed in educational settings and sponsored events.

Student Information:

1. Specific description of seizure symptoms (including, but not limited to, frequency, type, or length of seizures): ____
____
____.
2. Describe any activity restrictions specific to this student: ____
____.
3. List any signs/symptoms that may indicate an emergency situation and recommended interventions:
____
____.
4. List any concerns about transporting this student on the bus: ____
5. Emergency Rescue Medications needed on the bus: ☐ Yes ☐ No
6. VNS needs to be available on the bus: ☐ Yes ☐ No ☐ N/A
7. Other: ____
____
____.
8. Medication to be administered in the educational setting:

Please indicate Routine or Emergency/Rescue

Routine/Rescue	Medication Name	Dose	Route	Frequency

9. Potential adverse reactions: ____
____.
10. Latex Allergy: ☐ YES ☐ No

Protocol for seizure during school:

☐ Provide first aid – see Individualized Health-Care Plan (IHP)
☐ Provide emergency/rescue medication (per order below)
☐ Provide VNS therapy (per order below)
☐ Notify parent/emergency contact
☐ Notify credentialed school nurse
☐ Other: ___________

Emergency/Rescue Medication:

Specific description of seizure symptoms/circumstances (including, but not limited to, frequency, type, and length of seizures) that identify when the administration of an emergency/rescue medication is necessary:

____
____
____.

Student:	**DOB:**	**Date:**

If emergency/rescue medication is administered ____ minutes (30, if this section is left blank) prior to bussing, the student will not be transported by bus unless authorized by the credentialed school nurse.

The parent is to provide written notification to the district/school of the details (time, amount, etc.) of any emergency/rescue medication administered within ___ hours (4, if this section is left blank) before the start of a school day.

Call Emergency services ____. (If this section is left blank, emergency services will be called, and parent/guardian contacted following emergency anti-seizure medication administration which does not require that the student be transported to an emergency room. Emergency medical services protocol may require a parent/guardian to be present to avoid transport to the emergency room.) Emergency services may also be called according to legal requirements/school district policy and standard school emergency procedures. These requirements and/or policies may include: (a) emergency anti-seizure medication procedure may only be implemented for students who have been given the medication previously and without complications; (b) if emergency anti-seizure medication is administered to the student for the first time at school.

Vagus Nerve Stimulator (VNS):

1. Student is able to self-treat? ☐ Yes ☐ No
2. Initiate VNS magnet: ☐ at onset of aura: ____
   ☐ at start of seizure: ____
   ☐ other: ____
3. Swipe/hold magnet over VNS device for ____ seconds.
4. Swipe ____ times every ____ seconds and observe the student for further seizure activity.
5. If the student continues to have a seizure longer than ____ minutes:
   ☐ Call 9-1-1 ____
   ☐ Administer emergency anti-seizure medication ____

Authorized Health-Care Provider Authorization for Management in the Educational Setting

My signature below provides authorization for the above written orders. I understand all procedures will be implemented in accordance with state laws and regulations.

This authorization is for a maximum of one year. If changes are indicated, I will provide new written authorization. Authorizations may be faxed.

***Authorized Health-Care Provider Name** ________________________ ***NPI Number** ___________________________

Signature ____ **Date** ___________________

Phone ___________________ **Address** __________________________ **City** ___________________ **Zip** ____________

Supervising Physician Name ____ **NPI Number** _____________________

Phone ___________________ **Address** __________________________ **City** ___________________ **Zip** ____________

☐ I request that the credentialed school nurse provide me with a copy of the completed Individualized Health-Care Plan (IHP).

Authorization for Trained Unlicensed Person

Medication administration may be performed by a trained unlicensed person. ☐ **Yes** ☐ **No**

Health-Care Provider Signature: ___________________________ **Date:** ________________

Parent Signature: _______________________________________ **Date:** ________________

Parent Consent for Authorization and Management in the Educational Setting

I (we) the undersigned, the parent(s)/guardian(s) of the above-named student, request that the specialized physical health-care service be administered to my (our) child in accordance with state laws and regulations.

I (we) will:

1. provide the necessary supplies and equipment;
2. notify the credentialed school nurse if there is a change in child's health status or attending authorized health-care provider; and
3. notify the credentialed school nurse immediately and provide new written consent/authorization for any changes in the above authorization.

Student:	**DOB:**	**Date:**

I (we) give consent for the school nurse to communicate with the authorized health-care provider when necessary.
I (we) understand that I (we) will be provided a copy of my child's completed Individualized Health-Care Plan (IHP).

Parent(s)/Guardian(s) Signature: ____ **Date** ________________

____ **Date** ________________

Reviewed by credentialed school nurse (signature) ____ **Date** ________________

☐ **Credentialed school nurse has informed principal about health-care services provided for this student.**