Edmonds School District

HS 506

Student Health Services

Licensed Health Care Provider (LHCP) Authorization

For Administration of Emergency Anticonvulsant

Student's Name:_____ DOB: _____Grade: _____ School Year: _____

School: _____ Parent/Guardian Name: _____

Has this student ever received an Emergency anticonvulsant? ☐ Yes ☐ No Last date given:_____

Name of emergency medication: _____

Type of seizures: _____

This Portion to be Completed by a Licensed Healthcare Professional (LHCP)

(e.g., MD, DO, ARNP, DDS, etc.)

Diagnosis/ Condition	Medication	Dose	Route	Time/ Frequency	Side Effects	*Self Carry
						Y N
						Y N
						Y N
						Y N
						Y N
						Y N

SIDE EFFECT: respiratory depression, sleepiness

Administer: ☐ Diastat ☐ Midazolam ☐ Other: _____ by ☐ rectal ☐ nasal ☐ oral

Administer: _____ mg of medication after seizure of _____ minutes duration or _____.

***Marking "yes" to self-carry/administer indicates that the LHCP has provided instruction in the purpose and appropriate method/frequency of use, and that the student is capable and safe to self-carry and/or self-administer.**

I request and authorize that the above-named student receive the above-identified medications in accordance with the instructions indicated beginning ____/____/____ not to exceed the current school year and Summer School or otherwise specified____/____/____.

Clinic Stamp

LCHP's Signature:_____ **Date:**_____

LCHP's Name: _____ **Phone Number:** (_____)_____

LCHP's Address: _____ **Fax Number:** (_____) _____

Parent/Guardian Permission

The medication is to be furnished by me in the original container, labeled by the pharmacy with the name of the medicine, amount to be taken, and the time of day to be taken. The Licensed Health Care Provider's name is on the label. If medication remains after the course of treatment, I will collect the medication from the school or understand that it will be destroyed.

Signature of Parent/Guardian: _____ Date: _____

Student Signature (Self-Carrying):_____ Date: _____

Nurse Signature: _____ Date: _____

PLEASE TURN OVER TO COMPLETE THE OTHER SIDE

Administration of Medication in School

Medication should be given at school only when necessary. The school health room is staffed only during school hours and does not remain open for the duration of after-school clubs, athletic practices/games, concerts, dances, or other school-sponsored events. If the student must receive prescribed oral or topical medication, eye drops, ear drops, premixed nasal spray medications, or life-saving allergy medication during school hours or when the student is under the supervision by district staff and for official school events, the principal will designate and the school nurse will train and delegate school staff to administer medications and provide a plan to access medications. The medication to be given at school must have a written order signed by a Licensed Healthcare Professional (LHCP) working within the scope of their prescriptive authority and have a parent/guardian signature. Parents/guardians are responsible for ensuring medication and treatment supplies are available for their students. The medication must be in the original, properly labeled container. This includes any over the counter medication. Parents/guardians wishing for their student to self-carry and self-administer medications independently must provide signed medication orders from their LHCP explicitly stating this plan. Note students are not permitted to self-carry controlled substances. Students in K-5 grades are not recommended to self-carry. Students that self-carry medications does not relieve the parents/guardians of the annual health update, medication authorization orders, and health care plan each school year. Whenever possible the parent/guardian and LHCP are urged to design a medication schedule for administering medication if the student is participating in school sponsored activities outside of the normal school day hours. Edmonds School District accepts no responsibility for adverse reactions when the medication is dispensed in accordance with the LHCP order. Edmonds School District does not share private health information with outside entities without explicit written consent.

In addition, RCW 28A. 210.260, RCW 28A.210.355, and RCW 28A.210.330 allow parents of students with epilepsy or diabetes to select a "parent designated adult" to provide parent-directed nursing care in school.

Prior to participating in field trips, athletics, clubs, etc., parents/guardians of a student with healthcare conditions should consult with the school nurse to develop care considerations for the out-of-building environment.

The health care plan does not extend and apply to non-school sponsored activities. If a student attends extended before/after school care programs, or participates in non-school sponsored activities, parents/guardians are responsible for notifying that entity's program leadership of their student's healthcare and medication needs.

THIS PORTION TO BE COMPLETED BY PARENT/GUARDIAN

I the Parent/Guardian Understands:

When notified by school personnel that medication has expired, no longer is required as a course of treatment, or at the end of the school year, I am responsible for collecting the medication from the school or understand that it will be destroyed. Edmonds School District assumes no responsibility for self-carried and self-administered medications. In the event a safety issue arises, the school nurse has the right to notify the parent/guardian/student and discontinue the self-medication privilege. The student's health plan will be modified annually to reflect current health needs. I will provide the health information, medication authorization orders, unexpired medication in a properly labeled container and treatment supplies.

Optional: □ By checking this box I hereby give consent to have non-controlled medication returned home with student.

Student participates in:

- ❑ Athletics
- ❑ Music
- ❑ After-School Clubs
- ❑ Other School-Sponsored Activities _____

My signature below indicates that I have read and understand and will abide by the medication policy.

Signature of Parent/Guardian: _____Date: _____

Student Signature (Self-Carrying):_____Date:_____