TOWN OF FAIRFIELD SCHOOL HEALTH PROGRAM

AUTHORIZATION FOR ADMINISTRATION OF ANTI-EPILEPTIC MEDICATIONS IN SCHOOL

Connecticut State Law requires the written medication order of a physician or dentist licensed to practice in the United States or an Advanced Practice Registered Nurse, Physician's Assistant or Optometrist licensed to practice in Connecticut, and parent or guardian's written authorization for medications to be administered in school. All medications, prescription and non-prescription, shall be stored in their original container. All medications, except those approved for transporting by students for self-medication, shall be delivered to the school by the parent or guardian or other responsible adult. No more than a 3 month supply of medication may be kept at school. Medication will be administered by the School Nurse or other trained school personnel or by the student if he/she has been approved to self-administer the medication.

Name of Student: _____ Date of Birth:_____

TYPE of SEIZURE for which Medication is administered: _____

BRAND Name and GENERIC Name of Medication: _____

Dosage: _____Route: _____

WHEN to administer: Please check one:

_____For seizure activity over _____ minutes

_____At start of seizure activity

Administer Drug from_____to_____ (MM/DD/YY)

ADDITIONAL DIRECTIONS: _____

PLAN FOR DISPOSITION OF CHILD POST ADMINISTRATION OF MEDICATION: Please check one.

_____Call 911 and transport to hospital and inform parent

_____Call parent to pick up child

_____Alternate plan- _____

_____ _____ M.D./D.O./D.D.S./A.P.R.N./P.A.

Date Signature of Prescriber

_____

Print Name of Prescriber

_____

Address and Telephone

TOWN OF FAIRFIELD SCHOOL HEALTH PROGRAM

AUTHORIZATION OF PARENT OR GUARDIAN FOR ADMINISTRATION OF ANTI-EPILEPTIC MEDICATIONS IN SCHOOL

Connecticut State Law requires the written medication order of a physician or dentist licensed to practice in the United States or an Advanced Practice Registered Nurse, Physician's Assistant or Optometrist licensed to practice in Connecticut, and parent or guardian's written authorization for medications to be administered in school. All medications, prescription and non-prescription, shall be stored in their original container. All medications, except those approved for transporting by students for self-medication, shall be delivered to the school by the parent or guardian or other responsible adult. No more than a 3 month supply of medication may be kept at school. Medication will be administered by the School Nurse or other trained school personnel or by the student if he/she has been approved to self-administer the medication.

Name of Student_____ Date of Birth_____

School_____Grade_____

Anti-Epileptic Medication_____

I hereby give my permission for my child to receive the above medication in school as ordered by his/her physician or other authorized prescriber.

I give my permission for communication between the school nurse and prescriber of this medication as needed for implementation of that medication order in school.

I authorize that this medication be **destroyed** if it is not picked up within one week following termination of the medication order or by dismissal on the last day of school, whichever comes first.

_____ _____ _____

Date Signature of Parent or Guardian Telephone

_____

Print Name of Parent or Guardian