

Epilepsy Medication/ Emergency Procedure Doctor's Orders

School Year: _____

To be completed by legal prescriber

Name of Student: _____ Date of Birth: _____

School: _____ School Phone/Fax: _____

Diagnosis: _____

List any known drug allergies or other allergies: _____

	Medication / Procedure	Dosage	Route	Indication/Action
School Day Orders	Diastat or other _____	_____ _____	Rectal Intranasal	For seizure activity lasting more than ____ minutes. Other Indication/s: ____ Call EMS after administering Emergency Medication
School Bus Transportation Orders	Observe Student for seizure activity	N/A	N/A	If seizure activity is detected, pull bus over, protect student from injury and call EMS
Additional Instructions:				

This student's specific health information will be used by the school nurse to individualize the CCSD Health Management Plan and Emergency Action Plan. This plan will be used by the nurse to train the appropriate school employees.

 Legal Prescriber, print name **Signature of Legal Prescriber** Date Phone/Fax

Signature of Parent/Legal Guardian Date Phone Email