SEIZURE MEDICATION PERMISSION AND INSTRUCTION

HEALTH SERVICES
SCHOOL DISTRICT U-46

School Year:____________

PARENT PERMISSION: Please PRINT information:

Student Name: ______________________________ Date of Birth: ______________
Last Name, First Name — Month Day Year

Address: ____
House Number / Street — Apt # if necessary — City — ZIP

School: __________________________ Grade:_______ Teacher: ______________
Name of School — Teacher's Name

☐ I give my permission for the above named student to receive rectal/buccal/g-tube/Intranasal medication for treatment of status epilepticus

☐ I give permission for the school nurse to communicate as warranted with the physician regarding my student's health concerns.

Printed Name: ____________________ Home Phone: _______ Work Phone: _______
Parent/Guardian printed name — area code + number — area code + number

Signature: _________________________________ Date of signature:__________
Signature of Parent/Guardian — Month Day Year

PHYSICIAN INSTRUCTION:

☐ I request that the above named student to receive emergency medication for treatment of status epilepticus.

PHYSICIAN'S ORDERS: (to be completed by student's physician)

1. **Medication**: ____
   Dose: ____________ Route________________ Frequency:___________________
   Diagnosis: ____
   Side effects: ____

☐ SPECIFIC INSTRUCTION (s):____

____

If seizures do not subside in _________minutes administer emergency medication.

IF ANY EMERGENCY MEDICATIONS ARE ADMINISTERED, THE LOCAL EMS, 911 WILL BE ACTIVATED

Signature: ____________________________________ Date of signature:________
Signature of Physician — Month Day Year

Physician's Printed Name: ____
Physician's printed name — Medical Group/Clinic

Office Address: ____
Street Address — Suite # if necessary — City — ZIP

Office Phone: ______________________________ Fax Number:________________
area code + number — area code + number