

Medical Authorization for Emergency Management of Seizures at School

Student: _____ Birth Date: _____ Grade: _____

THIS PORTION TO BE COMPLETED BY THE PARENT/GUARDIAN

Parent Section Seccion De Padres	<p>I, the undersigned parent/guardian of the named student, request that all procedures and administration of medication be performed as authorized by the Health Care Provider in accordance with state laws and regulations. I understand and agree to:</p> <p><i>Yo, el padre o tutor legal del alumno nombrado en este documento, pido que todo procedimiento médico o administración de medicamento se realice de forma autorizada por el médico de acuerdo con las reglas y las leyes estatales. Entiendo y estoy de acuerdo con lo siguiente:</i></p> <ol style="list-style-type: none"> 1. Notify the school nurse if the medication was administered to my child within 12 hours of attending school. <i>Avisaré a la enfermera escolar si es que mi hijo tomó medicamento a menos de 12 horas de haber asistido a la escuela.</i> 2. Notify the school nurse of any changes in my child's seizure activity. <i>Avisaré a la enfermera escolar de cualquier cambio en convulsiones.</i> 3. Maintain current phone numbers with the school. <i>Mantendré actualizados mis números telefónicos con la escuela.</i> 4. Provide the necessary medication, supplies, and equipment. <i>Traeré el medicamento, suministro y equipo necesario.</i> 5. 911 will be called whenever this medication is used. <i>Se llamará al 911 cuando se use este medicamento.</i> <p>I authorize the school nurse to communicate with the Health Care Provider on matters related to my child's seizure disorder, medication, and school treatment plan. I understand that expired medications will be properly disposed of by the school nurse unless otherwise requested. <i>Yo autorizo a la enfermera escolar que se comuniquen con el médico de mi hijo en cuanto a convulsiones, medicamento y el plan de tratamiento escolar. También entiendo que los medicamentos expirados estarán adecuadamente desechados por la enfermera de la escuela, a menos que los solicite.</i></p> <p style="text-align: right; margin-right: 100px;">/</p> <p>Signature/Firma _____ Date/Fecha _____ Phone #1/Phone #2 _____</p> <p>Date of last seizure / Fecha de la última convulsión: _____ Length of last seizure/Duración de la última convulsión: _____</p> <p>Hospitalized/Hospitalizado: <input type="checkbox"/>Yes <input type="checkbox"/>No Emergency Medication given/Se administró medicamento de emergencia: <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Describe symptoms of previous seizures/describa los síntomas previos a la convulsión: _____</p> <p>What are your student's triggers/Cuales son los causantes de las convulsiones de su estudiante: _____</p>
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THIS PORTION TO BE COMPLETED BY THE HEALTH CARE PROVIDER

<p>Student's Grand Mal Seizures are: <input type="checkbox"/>Controlled, no meds <input type="checkbox"/>Controlled, with daily meds <input type="checkbox"/>Uncontrolled</p> <p>Student required Emergency Seizure medication at school: <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Reasoning: _____</p> <p>Medication: <input type="checkbox"/>Rectal Diastat <input type="checkbox"/> Nasal Midazolam <input type="checkbox"/>Nasal Valtoco Dosage: _____</p> <p>To be given AS NEEDED. Medical Provider to specify indications for usage: _____</p> <p>Emergency Procedure: Call 911, follow student's care plan, call parent/guardian and/or _____</p> <p>Medication Side Effects: _____</p> <p>Medication order is valid for duration of school year _____ (including summer school)</p> <p>I authorize the above named student to be administered this medication at school as directed.</p> <p style="text-align: center; margin-top: 20px;">_____</p> <p style="display: flex; justify-content: space-between;"> Healthcare Provider Signature Healthcare Provider Print </p> <p style="display: flex; justify-content: space-between; margin-top: 10px;"> Phone # _____ Fax # _____ Date _____ </p>
