SEIZURE MEDICATION AUTHORIZATION AND EMERGENCY ACTION PLAN FOR CMS STUDENTS

If Submitting by Fax (School Nurse Fax Number):		
Student's Name (Print):	**Student's Date of Birth:**	**For School Use Only**
		Date Received/Receiver's Signature: **Medication Received?** ❒ yes ❒ no
School's Name/Phone Number:	**Teacher/Grade:**	**Date Approved/Nurse's Signature** **Entered in EHR?** ❒ yes ❒ no
Preferred Hospital:	**Emergency contact and number:**	

In order to help protect each student's health, parent/legal guardian consent and written authorization from a licensed healthcare provider authorized to practice in North Carolina with prescribing rights are required when it is necessary for students to receive prescription or over-the-counter medications in Charlotte-Mecklenburg Schools. Additional documentation may be required for some medications (examples: research medications, medications with potential for immediate serious side effects). Some medications may not be suitable for a school setting. Contact the School Nurse if you have questions.

SECTION 1: LICENSED HEALTHCARE PROVIDER AUTHORIZATION (Please write legibly; use lay terms.)

Medication (generic/brand):	**Dose:**	**Route:**	**Administer if seizure is longer than_____ minutes in duration.**
Medication instructions:			

SEIZURE Emergency Action Plan:

- Observe seizure activity and time the seizure. Assist student to side lying position, loosen clothing around neck, remove glasses and clear area. Remain with the student. Call front office for the school nurse and First Responder.
- Administer medication as directed above and document on the student's medication administration record (MAR).
- Assess student for specific behaviors and movements during the seizure and complete the seizure flow sheet.
- Notify parent/guardian. Student must be picked up from school.
- Observe for decreased breathing or heart rate, change in color, head injury at time of seizure, duration and number of seizures. Begin artificial breathing if indicated. Nurse will monitor vital signs.
- Other information:
- Call 911 if: _____

In my professional opinion, it is necessary for this student to receive this medication during school hours in order to maintain/improve health and school attendance. Please notify the principal and/or school nurse and parents/guardians if there are any problems.

Stamp/Print/Type Healthcare Provider's Name & Address:	**Office Phone:** **Office Fax:**	**Healthcare Provider Signature:** **Date:**

SECTION 2: PARENT / LEGAL GUARDIAN CONSENT

I understand that: No medication will be given at school until this authorization has been received and verified by a School Nurse. A separate form is required for each medication. New authorization forms are required at the beginning of each school year, when the dose or directions change, and when a new medication is prescribed. It is my responsibility to supply the medication. Each medication must be in an appropriately labeled original container from the pharmacy or healthcare provider's office (many pharmacies will provide an extra container for school use upon request). Information about this medication and my child's health may be shared with other school staff or agents of the school if needed to help assure my child's safety and success at school.

- I give permission for my child to receive the medication described above during school hours.
- I give permission for the school nurse to contact the healthcare provider who prescribed the medication and the pharmacy where the prescription was filled to discuss this medication and my child's health if needed.
- I give permission for the healthcare provider, pharmacist and their staff to provide information to the school nurse about this medication and my child's health.
- On behalf of my child, I absolve the Charlotte-Mecklenburg Board of Education, their agents and employees from any and all liability whatsoever that may result from my child taking this medication at school.
- I have reviewed this order and give my permission for the School Health Nurse to train school personnel to follow this order.

Parent/Legal Guardian Signature: **Date:**	**Phone Numbers (mobile, work, home):**
Parent/Legal Guadian (Print Name):	