



# Emergency or Routine Seizure Medication

Student's name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ School/Grade/Teacher: \_\_\_\_\_

- The student's Ohio licensed health care prescriber must complete and sign Section I of this form each school year.
- Parent/guardian must complete and sign Section II of this form each school year.
- This completed form must be on file in the student's health record before medication will be administered by school personnel. **A separate form is required for each medication.**
- Medication must be in the original container as dispensed by the physician, pharmacist, or manufacturer. This medication will be stored in the school clinic unless prescriber authorizes the student to self-carry the medication.

## I. Prescriber's Section

Prescriber's name/title (printed): \_\_\_\_\_ Phone: \_\_\_\_\_

This is to certify that the student named above is under my care and should receive the following medication at the following times during the school day:

Medication name and strength	
Dose	
Route	
Time / circumstances for administration	
Severe adverse reactions to be reported to prescriber	
Adverse reaction for an unauthorized user	
Special instructions for administration	
Possible side effects	
Procedure to follow if medication doesn't produce desired effects:	
Special storage instructions	
Other special instructions	
Starting & ending date of this request	Start _____ End _____

Prescriber's signature/title: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Emergency contact #: \_\_\_\_\_

## II. Parent/Guardian's Section

I hereby request and give my permission for school district personnel to administer this prescribed medication to my child in accordance with the specific written orders from our medical provider. I do hereby release all school employees and the Board of Education from liability for damages, illness, or injury resulting from either performing or not performing any assistance requested.

I am responsible for the delivery of this medication to the school clinic and will notify the school (if applicable) immediately if we change our medical provider or the need for this medication is discontinued.

I agree to submit a revised *Emergency or Routine Seizure Medication* (form 5330 F5) if any changes are made regarding the above medication.

I understand this medication can only be administered to my child by a school nurse, myself, or this student until medically unlicensed staff in my child's school have completed the required District training. In the absence of a medically licensed person, such as a school nurse, only designated, trained staff are authorized to perform this task.

If this medication is required for extracurricular activities, I agree to provide a separate dose to school staff supervising my child's extracurricular activities.

I consent to communication between the prescribing health care provider or clinic, the school nurse, the school medical advisor and school-based health clinic providers as necessary for medical management.

Parent/Guardian signature: \_\_\_\_\_ Date: \_\_\_\_\_

Home address: \_\_\_\_\_ Daytime phone: \_\_\_\_\_

