

SEIZURE RESCUE MEDICATION ADMINISTRATION AUTHORIZATION

Student's Name: _____ Date of Birth: _____ School: _____

..... This section to be completed by HEALTH CARE PROVIDER

Diagnosis/Type of Seizure:
Medication:
Dose:
Route:
When to administer:
If PRN, time between doses:
Possible side effects:
Duration of Order: ☐ _____ school year, including summer school ☐ Other Dates: _____

LWSD schools do not staff a nurse on site during all school hours. In the event a nurse is not on site the medication may be administered by a non-licensed staff member who has received appropriate training and delegation from the registered nurse. If no trained staff member is on site and/or able to administer the medication, the school will call 911 and request a paramedic. Response times vary depending on location.

I request and authorize that the above-named student be administered the above-named medication in accordance with the instructions indicated. There exists a valid health reason which makes administration of the medication advisable during school hours or during such time that the student is under the supervision of school officials. Medication may be administered by non-licensed school personnel.

Health Care Provider Signature Printed Name Date Phone Number Fax Number

..... This section is to be completed by PARENT/GUARDIAN

- I authorize the school to administer the above-named medication to my student as prescribed.
- I understand that over-the-counter medication must be in its original container with a valid expiration date, and prescription medication must have a pharmacy label matching the written order above. It is my responsibility to replace medication when it is used or expired.

Signature of Parent/Guardian

Printed Name

Date