

JEFFERSON PARISH SCHOOLS

Supplemental Medication Order Form for Administration of Emergency Seizure Medications in School (Diatstat, Valtoco, Nayzilam)

(Please attach this to completed State of Louisiana Medication order form)

Student's Name: _____ DOB: _____

School: _____ Grade: _____

Parent of Legal Guardian Name (Print): _____

Parent of Legal Guardian Signature: _____ Date: _____

Description of the seizure for which emergency medication is ordered:

The student has a warning before the seizure No Yes (please specify): _____

This student's seizures may include: (Check all that apply)

- | | | |
|--|---|---|
| ☐ Deviation of head | ☐ Incontinence | ☐ Repetitive behavior |
| ☐ Deviation of eyes | ☐ Jerking movements | ☐ Lip smacking/chewing |
| ☐ Tremors | ☐ Cyanosis | ☐ Verbal outbursts |
| ☐ Drainage from mouth | ☐ Paralysis | ☐ Other symptoms |
| ☐ Stiffening or twitching | ☐ Unresponsive staring | ☐ _____ |

Administration of Emergency Seizure Medication

Medication: _____ Strength of Medication: _____

Dosage: _____ mg Frequency: _____ Route: _____

Indication:

For seizure activity described above lasting _____ minutes in duration.

If _____ (indicate number) of seizures occur within _____ (period of time).

- ☐ This child has never received any rescue medication for seizure activity, but he/she can receive it at school for the first time.
- ☐ This child has received rescue medication before and experienced no complications.

**Per district policy, school dosing must follow current FDA approved medication labeling.*

Notification

I wish to be notified if this medication is administered. No Yes

Medication on the Bus

If this student has a seizure while on the bus, emergency seizure medication will not be administered. The bus driver will stop the bus and call 911.

Comments: _____

Prescriber's name (printed) _____ Address _____

State license number _____ Date _____

Prescriber's signature _____ Phone/Fax _____