Delphos City Schools

MEDICATION INFORMATION FORM

FOR THE ADMINISTRATION AND/OR SELF-POSSESSION OF EMERGENCY SEIZURE MEDICATION

Many students are receiving medication under a doctor's supervision. It is important that the school be aware of the effects the medication might have or is having on the school performance of the students. School personnel are occasionally requested to administer the medication. Under these circumstances, it is necessary that specific physician's recommendations be made available to the school.

NAME OF STUDENT: _____ DATE OF BIRTH: _____

BLDG. _____ GRADE: _____ TEACHER : _____

STUDENT ADDRESS: _____

NAME OF EMERGENCY SEIZURE MEDICATION: _____

RECOMMENDED DOSAGE & ROUTE (rectal, nasal, etc.): _____

MEDICATION TO START: _____ END DATE: (if known) _____

TIMES ADMINISTERED (if seizure lasts _ min): _____

OTHER MEDICATIONS STUDENT IS TAKING: _____

SPECIAL INSTRUCTIONS FOR ADMINISTRATION OR STORAGE OF MEDICATION: _____

_____

REACTIONS: The physician/pharmacologist is urged to list potential reactions the student might have to the medication:

_____

Procedure instructions for school personnel to follow if emergency seizure medication does not produce expected relief from seizure: _____

_____

Other special instructions from the physician: _____

During school hours, it is my understanding that the school secretary, principal, school nurse AND/OR the above stated child will administer the prescribed medication according to the specified physician's recommendation. The school nurse may contact this physician at any time for information about my child's condition or health care plan. I agree to submit a revised statement signed by the prescriber if any of the information provided on this form changes. This form is valid for the current school year only and will serve as a Medical Release Form between school and healthcare provider.

The above stated child has been instructed on proper use, storage, and administration of the prescribed emergency seizure medication and has demonstrated competency in self administration. ☐ ***Yes*** ☐ ***No***

Please check one : ☐ Emeregncy seizure medication may be kept **with student**

☐ Emergency seizure medication must be kept **in the office**

(Parent and Physician signatures required below)

Parent Signature: _____ Phone: _____ Date: _____

Physician Signature: _____ Phone: _____ Date: _____

SEIZURE CARE PLAN

STUDENT NAME: _____ DATE OF BIRTH: _____

You have indicated that the above named student currently has **SEIZURES**. It is important to have at least annual health information when she/he needs help at school. Please complete this form so a plan can be established and shared with appropriate school personnel. It is the responsibility of the parent/guardian to provide necessary special food, medicine and treatment equipment needed at school. All students using an emergency seizure medication must follow district guidelines for medication use. If you have any questions, please call the school nurse. **REMEMBER TO NOTIFY SCHOOL IMMEDIATELY OF ANY CHANGES IN PHONE NUMBERS, CONTACT PERSONS, ETC.**

Describe typical seizure: _____ Length of seizures: _____

Forewarning signs: _____ Triggers: _____

After seizure behavior/needs: _____ Frequency of seizures: _____

Date of last seizure: _____ Emergency medication administered? ❑ No ❑ Yes

Has emergency medical treatment been necessary in the past year for seizures? ❑ No ❑ Yes - When? _____

Indicate the signs that are typically present when seizure activity occurs:

❑ Loss of consciousness ❑ Bluish color around mouth ❑ Unusual behavior - What? _____

❑ Staring ❑ Loss of bladder/bowel control ❑ Jerking movements - Where? _____

Epilepsy Provider: _____ Phone: _____

Preferred Hospital: _____

Are medications needed to manage seizures? List below the medications needed.

Medication	Amount taken	Route	Time of Day	Taken at school [1]

The usual procedure followed at school for seizures is:

1. **Begin timing the seizure.**
2. **Remove harmful objects, protect the head, turn on side, keep the airway clear, and do not put objects in the mouth.**
3. **Give rescue therapy according to seizure action plan.[1]**
4. **Stay with student until recovered from seizure.**
5. **School personnel will notify emergency contact.**
6. **Call 911 if:**
    a. **Seizure with loss of consciousness for longer than 3 minutes.**
    b. **Not responding to rescue medication if available.**
    c. **Repeated seizures longer than 10 minutes or no recovery between repeated seizures.**
    d. **Difficulty breathing.**
    e. **Serious injury occurs or is suspected.**

Please indicate any additional information[2] _____

_____

[1]The district medication policy requires parental and physician signature on district forms for all medications administered during school activities.
[2]Any treatments or test and activity restrictions require written directions from the student's physician or primary care provider.

(Parent and Physician signatures required below)

Parent Signature: _____ Phone: _____ Date: _____
Physician Signature: _____ Phone: _____ Date: _____

Updated: 9/2026