

Notice to Families Regarding Medication Administration



Dear Parent/Guardian:

To protect your child's safety, the school licensed practical nurse (LPN) and/or Health Aide (as designated by the principal) will adhere to the following medication administration requirements. It is required that BOTH legal guardian AND physician signatures are on file before any prescription can be given.

Although this may cause some inconvenience, we believe these requirements are best for the continued protection of your child's safety and therefore must be followed. If we do not have your written permission and the written permission of your physician, the medication will not be given. Permission forms can be obtained by contacting your school LPN, Health Aide, or the school office.

For your child to receive any medication at school, please follow the requirements below:

- All Action/Care Plans will need to be submitted with a Medication Consent form.
- Medication Consent Form must be completed and signed by physician and parent/legal guardian. **NO VERBAL CONSENT OR PHONE CONSENT WILL BE ACCEPTED.**
- New permission forms must be re-submitted each school year and are necessary for any changes in medication orders.
- Parent/Legal Guardian must notify the school if a student's physician changes or if the prescription is changed or discontinued.
- Prescription medication must be in the original container with the pharmacy (U.S.A. only) label. The container must have a proper label with the name of the patient, the name of the medicine, and the dosage.
- Only students with written authorization from their physician and parents/legal guardian are allowed to self-carry emergency medications. This authorization shall be provided to the clinic prior to the student's ability to self-carry emergency medications.
- Medication will be kept in a secure place in the health clinic during school hours. No medication shall be held in classrooms or backpacks at any time. Any medications brought in by students or found in a student's possession will be taken to the health clinic and remain in the clinic until a parent/legal guardian signs the consent form or picks up medication.
- The medication and the signed permission forms must be brought to the school by the parent/legal guardian and delivered to the campus clinic LPN or Health Aide. Students are not to be sent to campus with medications.
- Wherever possible, please include a photo of your child with the permission form.
- It is the parent/legal guardian's responsibility to deliver the medication to the school health clinic and have the medication picked up at the end of the year. Medication not picked up by the end of the year will be discarded.
- When the medication is almost completed, please bring the refill to school promptly. Parents must bring refill of medication to the clinic. Can not be brought in by student.
- If your student is taken off medication, will no longer receive it at school, or if the prescription otherwise changes, a dated, written note with updated prescription information of such changes must be provided. If medication is not picked up from the school office within ten (10) days, it will be properly disposed of.
- Medication that is expired or has a listed discard date will not be administered to students past indicated date.
- The first dose of any new medication shall not be administered at school due to the possibility of an allergic reaction.

Please contact the principal or their designee if you have any questions. Thank you for your cooperation.

Estimado Padre / Tutor:

Para proteger la seguridad de su hijo, la enfermera practicante con licencia de la escuela y/o el asistente de salud (según lo designe el director) se adherirá a la siguiente política de medicamentos. Se requiere que AMBOS padres y las firmas del médico estén archivadas antes de cualquier receta.

Aunque esto puede causar algunos inconvenientes, creemos que esta política es la mejor para la protección continua de la seguridad de su hijo y, por lo tanto, debe seguirse. Si no tenemos su permiso por escrito y el permiso por escrito de su médico, no se administrará el medicamento. Los formularios de permiso se pueden obtener comunicándose con la enfermera práctica autorizada o el asistente de salud de su escuela o con la oficina de la escuela.

Para que su hijo reciba cualquier medicamento en la escuela, siga la siguiente política de medicamentos:

Todos los planes de acción/cuidado deberán presentarse con un formulario de consentimiento de medicamentos.

- El formulario de consentimiento de administración debe ser completado y firmado por un médico, padre o tutor legal. **NO SE ACEPTARÁ CONSENTIMIENTO VERBAL NI TELEFÓNICO.**
- Los nuevos formularios de permiso deben volver a presentarse cada año escolar y son necesarios para cualquier cambio en las órdenes de medicamentos.
- Acepto notificar a la escuela si cambio de médico o si la receta se cambia o se interrumpe.
- Los medicamentos recetados deben estar en el envase original con la etiqueta de la farmacia (solo en EE. UU.). El envase debe tener una etiqueta adecuada con el nombre del paciente, el nombre del medicamento y la dosis.
- Solo los estudiantes con autorización por escrito de su médico y sus padres pueden llevar sus propios medicamentos. Esta autorización se proporcionará a la clínica antes de que el estudiante pueda llevar consigo los medicamentos de emergencia.
- Los medicamentos se mantendrán en un lugar seguro en la clínica de salud durante el horario escolar. No se guardarán medicamentos en las aulas o mochilas en ningún momento. Cualquier medicamento traído por los estudiantes o que se encuentre en posesión de un estudiante será llevado a la clínica de salud y permanecerá en la clínica hasta que un padre firme el formulario de consentimiento o recoja el medicamento.
- El medicamento y los formularios de permiso firmados deben ser llevados a la escuela por el padre o tutor y entregados al asistente de salud de la clínica del campus. Los estudiantes no deben ser enviados al campus con medicamentos.
- Siempre que sea posible, incluya una foto de su hijo con el formulario de autorización.
- Es responsabilidad del padre o tutor entregar el medicamento a la clínica de salud de la escuela y recoger el medicamento al final del año. Los medicamentos que no sean recogidos al final del año serán desechados.
- Cuando el medicamento esté casi terminado, envíe la recarga a la escuela de inmediato. No envíe resurtidos de medicamentos con el estudiante; los padres deben traerlos.
- Si a su hijo se le retira el medicamento, ya no lo recibirá en la escuela, o si la receta cambia de otro modo, proporcione una nota escrita con fecha con información actualizada de la receta de dichos cambios tan pronto como sea posible. Si el medicamento no se recoge en la oficina de la escuela dentro de los diez (10) días, se desechará correctamente.
- Los medicamentos que estén vencidos o que tengan una fecha de descarte indicada no se administrarán a los estudiantes después de la fecha indicada.
- La primera dosis de cualquier medicamento nuevo no se administrará en la escuela debido a la posibilidad de una reacción alérgica.

Comuníquese con el director o su designado si tiene alguna pregunta. Gracias por su cooperación.

Seizure Management and Treatment Plan Form



This form is designed to help create a plan for managing student seizures. It consists of questions about seizure history, medications, precautions, and other considerations. This form should be completed jointly by the student's parents and treating physician and provided to the campus nurse or other appropriately identified personnel.

Student Name: _____ **Date of Birth:** _____ **Date:** _____

Parent/Guardian: _____ **Phone:** _____ **Email:** _____

**Emergency Contact/
Relationship:** _____ **Phone:** _____ **Email:** _____

Seizure Information

Seizure Type	Length (How long it lasts)	Frequency (How often)	What Happens During a Seizure

Known Seizure Triggers or Warning Signs

- Missed Medicine
- Emotional Stress
- Lack of Sleep
- Physical Stress
- Flashing Lights
- Missing Meals
- Illness with High Fever
- Alcohol/Drugs
- Menstrual Cycle

Response to specific food or excess caffeine. Specify:

Other: _____

VNS/Devices

Devices: VNS RNS DBS

Date Implanted: _____

Magnet Use/Instructions:

Basic first aid to be provided during a seizure

- **STAY** calm, keep calm, begin timing the seizure
- Keep the student **SAFE**: remove harmful objects, don't restrain, and protect their head
- Turn the student on **SIDE** if not awake, keep airway clear, don't put objects in mouth
- **STAY** until the student recovers
- **SWIPE** magnet for VNS
- Write down what happened during the seizure
- Other: _____

When to call 911 - A seizure emergency for the student

- Seizure with a loss of consciousness longer than five minutes and not responding to rescue medicine if available
- Repeated seizures lasting longer than 10 minutes, with no recovery between them and the student is not responding to available rescue medicine
- Difficulty breathing after seizure
- Serious injury occurs or is suspected; seizure in water

When to call student's doctor first

- A change in seizure type, number, or pattern
- Student does not return to usual behavior (i.e., confused for a long period)
- A first time seizure that stops on its own
- Other medical problems or a pregnancy needs to be checked

Student name: _____ Date of birth: _____

Seizure Emergency Protocol for District Personnel to Follow

- Administer emergency medications _____
- Contact school nurse: _____
- Call 911; transport to _____
- Notify parent or emergency contact and doctor _____
- Other: _____

When and What to Do When Rescue Therapy is Needed

If seizure (cluster, # or length): _____

Name of Med/Rx: _____

How much to give (dose): _____

How to give: _____

If seizure (cluster, # or length): _____

Name of Med/Rx: _____

How much to give (dose): _____

How to give: _____

Student's Response and Care After a Seizure

What type of help is needed? _____

When is the student able to resume usual activity? _____

Does the student need to leave the classroom? Yes No

If yes, when can the student return to the classroom? _____

Is the student able to manage and understand their seizures? Yes No

Special Instructions

First Responders: _____

Emergency Department: _____

Daily Seizure Medication

Medication Name	Dosage	Time to be Given	Common Side Effects	Special Instructions

Other Information

Important medical history: _____

Allergies: _____

Epilepsy surgery (type, date, side effects): _____

Diet therapy: Ketogenic Low-Glycemic Modified Atkins Other: _____

Special considerations, instructions, or precautions (i.e., school trips, activities, sports, etc.): _____

Health Care Contacts

Epilepsy Provider: _____ Phone: _____

Primary Care: _____ Phone: _____

Preferred Hospital: _____ Phone: _____

Pharmacy: _____ Phone: _____

Parent/Guardian Signature: _____ Date: _____

Epilepsy Provider Signature: _____ Date: _____



MEDICATION ADMINISTRATION CONSENT FORM

STUDENT INFORMATION **(Only 1 Medication Per Form)**

Student Name: _____ Date of Birth: _____

Address: _____ City/State/Zip: _____

School: _____ Grade: _____ Teacher: _____ School Year: _____

List any known drug allergies/reactions: _____ Height (inches): _____ Weight (lbs.): _____

Parent Name: _____ Phone Number: _____

PHYSICIAN AUTHORIZATION

(To be completed by physician/licensed prescriber)

Name of Medication: _____ Reason for taking: _____ ICD 10 CODE _____

Dosage: _____ Route: _____ Time(s) and Interval to be administered: _____

Replace Previous Order: Y N Begin/End Dates: _____

Special Instructions for Administration and Storage of Medication: _____

Is medication necessary to be given during school hours (7:30 AM to 3 PM)? Yes No

If yes, please provide recommended administration time(s): _____

Is the medication a controlled substance? Yes No Does medication require refrigeration? Yes No

Special Instructions or Storage: _____

Potential Side Effects/Contraindications/Adverse Reactions: _____

Treatment Order in the event of an adverse reaction: _____

(Attach additional sheet or use the back of this form if necessary)

Provider Name: _____ Provider Signature: _____

Phone Number: _____ Date: _____

PARENT AUTHORIZATION

(To be completed by parent/guardian)

- I authorize the delegated personnel the task of assisting my child with medication administration.
- I agree to notify the school if I change physicians or if the prescription is changed or discontinued.
- Only medication prescribed and provided by the United States will be administered in school.
- Medication that is expired or has a listed discard date will not be administered to students past indicated date.
- Prescription medication must be in the original container with the pharmacy (U.S.A. only) label. The container must have a proper label with the name of the patient, the name of the medicine, and the dosage.
- This Medication Administration Consent form must be completed and signed by physician, parent, or legal guardian. **NO VERBAL CONSENT OR PHONE CONSENT WILL BE ACCEPTED.**
- Medication will be kept in a secure place in the health clinic during school hours. No medication shall be held in classrooms or backpacks at any time. Any medications brought in by students or found in a student's possession will be taken to the health clinic and remain in the clinic until a parent signs the consent form or picks up medication.
- Only students with written authorization from their physician and parents are allowed to self-carry emergency medications. This authorization shall be provided to the clinic prior to the student's ability to self-carry emergency medications.
- It is the parent or guardian's responsibility to deliver the medication to the school health clinic and have the medication picked up at the end of the year. Medication not picked up by the end of the year will be discarded.
- The first dose of any new medication shall not be administered at school due to the possibility of an allergic reaction.

Parent/Guardian Name: _____ Parent/Guardian Signature: _____

Secondary Contact Number: _____ Date: _____



MEDICATION ADMINISTRATION CONSENT FORM

STUDENT INFORMATION (Only 1 Medication Per Form)

Student Name: _____ Date of Birth: _____
(Nombre del Estudiante) (Fecha de Nacimiento)
Address: _____ City/State/Zip: _____
(Dirección) (Ciudad/estado/código postal)
School: _____ Grade: _____ Teacher: _____ School Year: _____
(Escuela) (Grado) (Maestro/a) (Año escolar)
List any known drug allergies/reactions: _____ Height (inches): _____ Weight (lbs.): _____
(Alergia/Reacción Conocida a Medicamentos) (Altura) (Peso)
Parent Name: _____ Phone Number: _____
(Nombre del Padre) (Número de Teléfono)

PHYSICIAN AUTHORIZATION (To be completed by physician/licensed prescriber)

Name of Medication: _____ Reason for taking: _____ ICD 10 CODE _____
Dosage: _____ Route: _____ Time(s) and Interval to be administered: _____
Replace Previous Order: Y N Begin/End Dates: _____
Special Instructions for Administration and Storage of Medication: _____
Is medication necessary to be given during school hours (7:30 AM to 3 PM)? Yes No
If yes, please provide recommended administration time(s): _____
Is the medication a controlled substance? Yes No Does medication require refrigeration? Yes No
Special Instructions or Storage: _____
Potential Side Effects/Contraindications/Adverse Reactions: _____
Treatment Order in the event of an adverse reaction: _____
(Attach additional sheet or use the back of this form if necessary)
Provider Name: _____ Provider Signature: _____
Phone Number: _____ Date: _____

AUTORIZACIÓN DE LOS PADRES (Para ser completado por el padre/tutor)

- Autorizo al personal delegado la tarea de asistir a mi hijo en la administración de medicamentos.
- Acepto notificar a la escuela si cambio de médico o si la receta se cambia o se interrumpe.
- Sólo se administrarán en la escuela los medicamentos prescritos y proporcionados por los Estados Unidos.
- Los medicamentos que estén vencidos o que tengan una fecha de descarte indicada no se administrarán a los estudiantes después de la fecha indicada.
- Los medicamentos recetados deben estar en el envase original con la etiqueta de la farmacia (solo en EE. UU.). El envase debe tener una etiqueta adecuada con el nombre del paciente, el nombre del medicamento y la dosis.
- El formulario de consentimiento de administración debe ser completado y firmado por un médico, padre o tutor legal. **NO SE ACEPTARÁ CONSENTIMIENTO VERBAL NI TELEFÓNICO.**
- Los medicamentos se mantendrán en un lugar seguro en la clínica de salud durante el horario escolar. No se guardarán medicamentos en las aulas o mochilas en ningún momento. Cualquier medicamento traído por los estudiantes o que se encuentre en posesión de un estudiante será llevado a la clínica de salud y permanecerá en la clínica hasta que un padre firme el formulario de consentimiento o recoja el medicamento.
- Solo los estudiantes con autorización por escrito de su médico y sus padres pueden llevar sus propios medicamentos. Esta autorización se proporcionará a la clínica antes de que el estudiante pueda llevar consigo los medicamentos de emergencia.
- Es responsabilidad del padre o tutor entregar el medicamento a la clínica de salud de la escuela y recoger el medicamento al final del año. Los medicamentos que no sean recogidos al final del año serán desechados.
- La primera dosis de cualquier medicamento nuevo no se administrará en la escuela debido a la posibilidad de una reacción alérgica.

Parent/Guardian Name: _____ Parent/Guardian Signature: _____
(Nombre del Padre de Familia / Guardian) (Firma del Padre / Tutor)
Secondary Contact Number: _____ Date: _____
(Número de Contacto Secundario) (Fecha)