Notice to Families Regarding Medication Administration

Dear Parent/Guardian:

To protect your child's safety, the school personnel 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 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 receptionist. 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 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 campus. 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 Director of Student Support Services or designee if you have any questions. Thank you for your cooperation.

Aviso a las familias sobre la administración de medicamentos

Estimado Padre / Tutor:

Para proteger la seguridad de su hijo, el personal escolar designado por el director cumplirá con los siguientes requisitos para la administración de medicamentos. Se requiere que las firmas de AMBOS, el tutor legal Y el médico, estén registradas antes de que se pueda administrar cualquier medicamento recetado.

Aunque esto puede causar algunos inconvenientes, creemos que estos requisitos son los mejores para la protección continua de la seguridad de su hijo y, por lo tanto, deben cumplirse. Si no contamos con su autorización por escrito y la autorización por escrito de su médico, el medicamento no será administrado. Los formularios de autorización pueden obtenerse comunicándose con la oficina de su 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 autorización firmados deben ser llevados a la escuela por el padre, la madre o el tutor legal y entregados a la recepcionista del campus. No se debe enviar a los estudiantes al campus con medicamentos.
- Siempre que sea posible, incluya una foto de su hijo con el formulario de autorización.
- Es responsabilidad del padre/madre o tutor legal entregar el medicamento a la escuela y recogerlo al final del año. El medicamento que no sea recogido al final del año será desechado.
- Cuando el medicamento esté casi terminado, por favor lleve el resurtido a la escuela lo antes posible. Los padres deben llevar el resurtido del medicamento al campus. No puede ser traído por el estudiante.
- 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.

Por favor, comuníquese con el Director de Servicios de Apoyo Estudiantil o la persona designada si tiene alguna pregunta. Gracias por su cooperación.

SEIZURE ACTION PLAN (SAP)

EPILEPSY FOUNDATION | END EPILEPSY

Name: _____ Birth Date: _____

Address: _____ Phone: _____

Parent/Guardian: _____ Phone: _____

Emergency Contact/Relationship _____ Phone: _____

Seizure Information

Seizure Type	How Long It Lasts	How Often	What Happens

Protocol for seizure during school (check all that apply) ☑

- ☐ First aid – **Stay. Safe. Side.**
- ☐ Give rescue therapy according to SAP
- ☐ Notify parent/emergency contact
- ☐ Contact school nurse at _____
- ☐ Call 911 for transport to _____
- ☐ Other _____

First aid for any seizure

- ☐ **STAY** calm, keep calm, **begin timing seizure**
- ☐ Keep me **SAFE** – remove harmful objects, don't restrain, protect head
- ☐ **SIDE** – turn on side if not awake, keep airway clear, don't put objects in mouth
- ☐ **STAY** until recovered from seizure
- ☐ Swipe magnet for VNS
- ☐ Write down what happens _____
- ☐ Other _____

When to call 911

- ☐ Seizure with loss of consciousness longer than 5 minutes, not responding to rescue med if available
- ☐ Repeated seizures longer than 10 minutes, no recovery between them, not responding to rescue med if available
- ☐ Difficulty breathing after seizure
- ☐ Serious injury occurs or suspected, seizure in water

When to call your provider first

- ☐ Change in seizure type, number or pattern
- ☐ Person does not return to usual behavior (i.e., confused for a long period)
- ☐ First time seizure that stops on its' own
- ☐ Other medical problems or pregnancy need to be checked

When **rescue therapy** may be needed:

WHEN AND WHAT TO DO

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 _____

If seizure (cluster, # or length) _____

Name of Med/Rx _____ How much to give (dose) _____

How to give _____

Care after seizure

What type of help is needed? (describe) _____

When is student able to resume usual activity? _____

Special instructions

First Responders: _____

_____

Emergency Department: _____

_____

Daily seizure medicine

Medicine Name	Total Daily Amount	Amount of Tab/Liquid	How Taken (time of each dose and how much)

Other information

Triggers: _____

Important Medical History _____

Allergies _____

Epilepsy Surgery (type, date, side effects) _____

Device: ☐ VNS ☐ RNS ☐ DBS Date Implanted _____

Diet Therapy ☐ Ketogenic ☐ Low Glycemic ☐ Modified Atkins ☐ Other (describe) _____

Special Instructions: _____

_____

Health care contacts

Epilepsy Provider: _____ Phone: _____

Primary Care: _____ Phone: _____

Preferred Hospital: _____ Phone: _____

Pharmacy: _____ Phone: _____

My signature _____ Date _____

Provider signature _____ Date _____

Epilepsy.com

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EPILEPSY FOUNDATION | END EPILEPSY

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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/codigo 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)*