TOWN OF FAIRFIELD SCHOOL HEALTH PROGRAM

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION FOR SEIZURES IN SCHOOL

Connecticut State Law requires the written medication order of a physician or dentist licensed to practice in the United States or an Advanced Practice Registered Nurse, Physician's Assistant or Optometrist licensed to practice in Connecticut, and parent or guardian's written authorization for medications to be administered in school. All medications, prescription and non-prescription, shall be stored in their original container. All medications, except those approved for transporting by students for self-medication, shall be delivered to the school by the parent or guardian or other responsible adult. No more than a 3 month supply of medication may be kept at school. Medication will be administered by the School Nurse or other trained school personnel or by the student if he/she has been approved to self-administer the medication.

Name of Student_____ Date of Birth_____

BRAND Name **AND GENERIC** Name of Drug (**PER STATE REGULATION**)

_____

_____

Type of Seizure for which the drug is being administered **PLEASE CHECK ONE OR MORE**:

	Type of Seizure	Symptoms
	1. "Grand Mal" or Generalized tonic-clonic	Unconsciousness, convulsions, muscle rigidity
	2. Absence	Brief loss of consciousness
	3. Myoclonic	Sporadic (isolated), jerking movements
	4. Clonic	Repetitive, jerking movements
	5. Tonic	Muscle stiffness, rigidity
	6. Atonic	Loss of muscle tone
	7. Other	

Dosage:_____Route:_____Frequency: _____

Administer Drug: from_____to_____ (dates)

Side effects_____

ADDITIONAL DIRECTIONS: _____

PLAN FOR DISPOSITION OF CHILD POST ADMINISTRATION OF MEDICATION.

Please check one: ____ Call 911 and transport to hospital and inform parent ____ Call parent to pick up child

<u>SPECIAL INSTRUCTIONS</u>: IF DIASTAT (DIAZEPAM RECTAL GEL) IS ORDERED AND THE NURSE IS NOT AVAILABLE TO ADMINISTER DIASTAT (DIAZEPAM RECTAL GEL), DESIGNATED SCHOOL PERSONNEL WILL CALL 911 AT ONSET OF SEIZURE.

_____ _____ M.D./D.O./D.D.S./A.P.R.N./P.A.

Date Signature of Prescriber

_____

Print Name of Prescriber

_____

Address and Telephone

TOWN OF FAIRFIELD SCHOOL HEALTH PROGRAM

AUTHORIZATION OF PARENT OR GUARDIAN FOR ADMINISTRATION OF MEDICATION IN SCHOOL

Connecticut State Law requires the written medication order of a physician or dentist licensed to practice in the United States or an Advanced Practice Registered Nurse, Physician's Assistant or Optometrist licensed to practice in Connecticut, and parent or guardian's written authorization for medications to be administered in school. All medications, prescription and non-prescription, shall be stored in their original container. All medications, except those approved for transporting by students for self-medication, shall be delivered to the school by the parent or guardian or other responsible adult. No more than a 3 month supply of medication may be kept at school. Medication will be administered by the School Nurse or other trained school personnel or by the student if he/she has been approved to self-administer the medication.

Name of Student_____ Date of Birth_____

School_____Grade_____

Medication_____

I hereby give my permission for my child to receive the above medication in school as ordered by his/her physician or other authorized prescriber.

Self-administration of medication means that the student will carry and administer his/her medication without assistance.

Student may self-administer the above medication: (circle one): Yes No

For daily medication – Plan for early dismissal days (check one):

___ Give medication in school as usual

___ Do not give medication in school

- **Plan for delayed opening:**
  On days that opening of school is delayed, the parent or guardian must notify the school nurse if any change in the student's medication schedule is needed.

I give my permission for communication between the school nurse and prescriber of this medication as needed for implementation of that medication order in school.

I authorize that this medication be **destroyed** if it is not picked up within one week following termination of the medication order or by dismissal on the last day of school, whichever comes first.

_____ _____ _____

Date Signature of Parent or Guardian Telephone

_____

Print Name of Parent or Guardian