

Attach student photo here

SEIZURE MEDICATION ADMINISTRATION FORM

Provider Medication Order Form | Office of School Health | School Year **2020-2021**
 Please return to school nurse. Forms submitted after June 1st may delay processing for new school year.

Student Last Name	First Name	Middle	Date of birth ____/____/____ MM DD YYYY	<input type="checkbox"/> Male <input type="checkbox"/> Female
OSIS Number _____				
School (include name, number, address and borough)			DOE District	Grade
Class				

HEALTH CARE PRACTITIONERS COMPLETE BELOW

Diagnosis/Seizure Type:

Localization related (focal) epilepsy
 Primary generalized
 Secondary generalized
 Childhood/juvenile absence
 Myoclonic
 Infantile spasms
 Non-convulsive seizures
 Other (please describe)

Seizure Type	Duration	Frequency	Description	Triggers/Warning Signs

Post-ictal presentation: _____

Seizure/Status Epilepticus History: Describe history & most recent episode (date, trigger, pattern, duration, treatment, hospitalization, ED visits, etc.):

Has student had surgery for epilepsy? No Yes

TREATMENT PROTOCOL DURING SCHOOL:

A. In-School Medications

Student Skill Level (select the most appropriate option)

Nurse-Dependent Student: nurse/nurse-trained staff must administer
 Independent Student: student is self-carry/self-administer
 Supervised Student: student self-administers, under adult supervision
 I attest student demonstrated ability to self-administer the prescribed medication effectively for school/fieldtrips/school sponsored events.

Practitioner's Initials

Name of Medication	Concentration/Formulation	Dose	Route	Frequency or Time	Side Effects/Specific Instructions

B. Does student have a Vagal Nerve Stimulator (VNS)? (any trained adult can administer) No Yes, If YES, describe magnet use:
 Swipe magnet immediately within ____ min; if seizure continues, repeat after ____ min ____ times;
 Give emergency medication after ____ min and call 911

C. Emergency Medication(s) (list in order of administration) [Nurse must administer] ; CALL 911 immediately after administration

Name of Medication	Concentration/Preparation	Dose	Route	Administer Within	Side Effects/Special Instructions
				min	
				min	

ACTIVITIES:

Adaptive/protective equipment (e.g. helmet) used? No Yes If YES, please describe:
 Gym/physical activity participation restrictions? Yes No If YES, please describe:
 No contact sports
 1:1 for swimming
 Harness for climbing
 Field trips
 Other: _____

504 accommodations requested? Yes (attach form) No

Home Medication(s)	Dosage, Route, Directions	Side Effects/Special Instructions

Other special instructions: _____

Health Care Practitioner LAST NAME (Please print and check one: <input type="checkbox"/> MD, <input type="checkbox"/> DO, <input type="checkbox"/> NP, <input type="checkbox"/> PA)	FIRST NAME	Signature
Address	Tel. No. (____) ____-____	Fax. No (____) ____-____
E-mail address	Cell phone (____) ____-____	
NYS License No (Required)	NPI No.	Date ____/____/____

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PARENTS/GUARDIANS FILL BELOW

BY SIGNING BELOW, I AGREE TO THE FOLLOWING:

1. I consent to my child's medicine being stored and given at school based on directions from my child's health care practitioner. I also consent to any equipment needed for my child's medicine being stored and used at school.
2. **I understand that:**
 - I must give the school nurse my child's medicine and equipment.
 - **All prescription and "over-the-counter" medicine I give the school must be new, unopened, and in the original bottle or box.** I will get another medicine for my child to use when he or she is not in school or is on a school trip.
 - Prescription medicine must have the **original** pharmacy label on the box or bottle. Label must include: 1) my child's name, 2) pharmacy name and phone number, 3) my child's health care practitioner's name, 4) date, 5) number of refills, 6) name of medicine, 7) dosage, 8) when to take the medicine, 9) how to take the medicine and 10) any other directions.
 - I must **immediately** tell the school nurse about any change in my child's medicine or the health care practitioner's instructions.
 - **No student is allowed to carry or give him or herself controlled substances.**
 - The Office of School Health (OSH) and its agents involved in providing the above health service(s) to my child are relying on the accuracy of the information in this form.
 - By signing this medication administration form (MAF), OSH may provide health services to my child. These services may include a clinical assessment or a physical exam by an OSH health care practitioner or nurse.
 - The medication order in this MAF expires at the end of my child's school year, which may include the summer session, or when I give the school nurse a new MAF (whichever is earlier). When this medication order expires, I will give my child's school nurse a new MAF written by my child's health care practitioner. OSH will not need my signature for future MAFs.
 - This form represents my consent and request for the medication services described on this form. It is not an agreement by OSH to provide the requested services. If OSH decides to provide these services, my child may also need a Student Accommodation Plan. This plan will be completed by the school.
 - OSH may obtain any other information they think is needed about my child's medical condition, medication or treatment. OSH may obtain this information from any health care practitioner, nurse, or pharmacist who has given my child health services.
 - If the school nurse is unavailable, I may be notified to come to school to give my child medicine.

FOR SELF-ADMINISTRATION OF MEDICINE (Non-Emergency Medications):

- I certify/confirm that my child has been fully trained and can take medicine on his or her own. I consent to my child carrying, storing and giving him or herself the medicine prescribed on this form in school. I am responsible for giving my child this medicine in bottles or boxes as described above. I am also responsible for monitoring my child's medication use, and for all results of my child's use of this medicine in school. The school nurse will confirm my child's ability to carry and give him or herself medicine. I also agree to give the school "back up" medicine in a clearly labeled box or bottle.

NOTE: It is preferred that you send medication and equipment for your child on a school trip day and for off-site school activities.

Student Last Name		First Name		MI	Date of birth ___ / ___ / _____	
School Name/Number				Borough		District
Print Parent/Guardian's Name			SIGN HERE	Parent/Guardian's Signature		Date Signed ___ / ___ / _____
Parent/Guardian's Email				Parent/Guardian's Address		
Telephone Numbers: Daytime (____) ____ - ____ Home (____) ____ - ____ Cell Phone (____) ____ - ____						
Alternate Emergency Contact's Name		Relationship to Student		Contact Telephone Number (____) ____ - ____		

For Office of School Health (OSH) Use Only

OSIS Number: _____							
Received by: Name _____		Date ___ / ___ / _____		Reviewed by: Name _____		Date ___ / ___ / _____	
<input type="checkbox"/> 504	<input type="checkbox"/> IEP	<input type="checkbox"/> Other	Referred to School 504 Coordinator: <input type="checkbox"/> Yes <input type="checkbox"/> No				
Services provided by: <input type="checkbox"/> Nurse/NP		<input type="checkbox"/> OSH Public Health Advisor (for supervised students only)		<input type="checkbox"/> School Based Health Center			
Signature and Title (RN OR SMD): _____				Date School Notified & Form Sent to DOE Liaison ___ / ___ / _____			
Revisions as per OSH contact with prescribing health care practitioner				<input type="checkbox"/> Modified		<input type="checkbox"/> Not Modified	