Palo Alto
Unified School District

Medication Authorization
Emergency Anti-Seizure Medication

School Year: _____ School: _____ Fax: _____

Student Name: _____ Grade: _____ DOB: _____

*This form **must be renewed annually**, **and** if there are any changes in treatment or medication during the school year.*

Physician -- Complete Medication List Below *Mark* All That Apply

Medication Name: _____ Strength: _____ Required Dose: _____

Method of Administration: _____ PRN frequency: _____

Specific description of seizure symptoms (including but not limited to frequency, type or length of seizures) that identify when the administration of an emergency anti-seizure medication is necessary: _____

_____

Circumstances under which the medication may be administered: _____

Potential adverse reactions and recommended mitigation actions: _____

Protocol for observing student after a seizure (including but not limited to whether the student should rest in the school office, return to class, and the length of time student should be under direct observation: _____

The *parent/guardian* is to provider verbal and written notification to the student's school of the details (time, amount, etc.) of any emergency anti-seizure medication administration within 4 hours of the start of a school day. If parent notifies the school of any such administration, then the above protocol should be modified as follows (describe change if any to the above administration instructions in the event of a parent administration notification as described above):

_____

Date when emergency anti-seizure medication was last administered: _____ Other seizure medications prescribed for the student: _____

Medication shall be administered from: _____ to _____ or ☐ Remainder of school year

Additional Instructions: _____

My signature below provides authorization for the above orders. All procedures will be implemented in accordance with states laws and regulations. Specialized physical health care services may be performed by unlicensed designated school personnel under the training and supervision provided by the school nurse.

_____ _____

Physician Signature Date

_____ _____

Phone Fax Clinic Stamp

Parent/Guardian Consent

I request that my child be allowed to take medication at school according to instruction from the above health care provider. I authorize school personnel to assist with this medication for my child as ordered from the above health care provider. I understand trained, non-medical personnel may assist with or administer medication (Ed Code 49423 and 49480).

Health Services
25 Churchill Avenue
Palo Alto, CA 94306
Tel. 650-833-4240 | Fax 650-833-4226

Updated 3/22/2017

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Parent/Guardian Consent (cont.)

I give consent to communication and exchange of information between PAUSD, the health care provider listed above, and the pharmacy listed on the prescription medication above regarding the health care provider's written statement or any other questions about the medication or medication administration.

I understand and agree to the following responsibilities regarding medication administration:

1. This form must be renewed whenever student's prescription changes and at beginning of each school year.
2. Prescription medication must be in a container labeled by the pharmacist or health care provider and will not be expired.
3. Non-prescription medication must be in the original container with the label intact.
4. An adult must bring the medication to the school health office and pick up any outdated or unused medication.
5. Pill splitting must be done by parent/guardian prior to providing medication to school officials.
6. Parents/Guardians provide all materials or necessary equipment (e.g. measuring spoon) for medication administration.
7. Students may not carry and self-administer medication unless authorization has been given by student, parent, and health care provider.
8. Parents will notify the school and provide new consent for any changes to the above authorization.
9. Any modifications or changes to the above authorizations may only be made after written notification is received from the health care provider.
10. I understand that 911 will be called following emergency anti-seizure medication administration in accordance with California Ed. Code Section 49414.7. This shall not required that the student be transported to an emergency room; however, due to the administration of the emergency anti-seizure medication, if student is not transported by EMS he/she may not be able to remain in school for the remainder of the school day. This will be made by the school nurse on an individual basis and will be based upon the student's safety and medical needs. EMS protocol may require a parent/guardian to be present to avoid transport to emergency room
11. I understand that if emergency anti-seizure medication is administered, student will not be transpored by bus unless authorized by the district nurse.
12. I understand that parent/guardian *must let the school know* if the emergency anti-seizure medication was given within the past 4 hours on a school day (including dosage, method of administration, and seizure characteristics).
13. I understand that emergency anti-seizure medication will not be administered on a school bus. 911 will be called for qualifying seizure activity.

Parent Signature	Phone	Date

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