Attach student photo here

SEIZURE MEDICATION ADMINISTRATION FORM

Provider Medication Order Form | Office of School Health | School Year **2021–2022**

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	☐ Male ☐ 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 below)

Seizure Type	Duration	Frequency	Description	Triggers/Warning Signs/Pre-Ictal Phase

Post-ictal presentation:

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

Status Epilepticus? ☐ No ☐ Yes Has student had surgery for epilepsy? ☐No ☐Yes, date ____/____/____

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

☐ Supervised Student: student self-administers, under adult supervision

☐ Independent Student: student is self-carry/self-administer
I attest student demonstrated ability to self-administer the prescribed medication effectively during school, field trips, and school sponsored events.

Practitioner's Initials

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

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

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

C. 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

ACTIVITIES:

Adaptive/protective equipment (e.g. helmet) used? ☐ No ☐ Yes
Gym/physical activity participation restrictions? ☐ No ☐ Yes If YES, please complete the Medical Request for Accommodations Form
☐ **Other:**_____

504 accommodations requested (e.g., supervision for swimming)? ☐ Yes (*attach form*) ☐ No

Home Medication(s) ☐ None	**Dosage, Route, Directions**	**Side Effects/Special Instructions**

Other special instructions:

Health Care Practitioner LAST NAME (Please print and check one: ☐ MD, ☐ DO, ☐ NP, ☐ PA)	FIRST NAME	Signature
Address	Tel. No. (__ __ __) __ __ __- __ __ __ __	Fax. No (__ __ __) __ __ __- __ __ __ __
E-mail address	Cell phone (__ __ __) __ __ __- __ __ __ __	
NYS License No **(Required)** __ __ __ __ __ __ __ __	NPI No. __ __ __ __ __ __ __ __ __ __ __ __ __ __ __	Date __ __ / __ __ / __ __ __ __

INCOMPLETE PRACTITIONER INFORMATION WILL DELAY IMPLEMENTATION OF MEDICATION ORDERS

FORMS CANNOT BE COMPLETED BY A RESIDENT

PARENTS MUST SIGN PAGE 2 ➔

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PARENTS/GUARDIANS: READ, COMPLETE, AND SIGN. 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	**Parent/Guardian's Signature** SIGN HERE		**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 __/__/____

☐ **504** ☐ **IEP** ☐ **Other** **Referred to School 504 Coordinator**: ☐ Yes ☐ No

Services provided by: ☐ Nurse/NP ☐ OSH Public Health Advisor (for supervised students only) ☐ 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 ☐ Clarified ☐ Modified