

SEIZURE MEDICATION ADMINISTRATION FORM

Provider Medication Order Form I Office of School Health I School Year **2022-2023**Please return to school nurse. Forms submitted after June 1st may delay processing for new school year.

MEALTH CARE PRACTITIONERS COMPLETE BELOW Grade: Qass						-	, ,, ,	
MEALTH CARE PRACTITIONERS COMPLETE BELOW Grade: Gass	Student Last Name:		First N	Name:		Middle: _	Date of birth:	
### HEALTH CARE PRACTITIONERS COMPLETE BELOW Localization related (focal) epilepsy Primary generalized Secondary generalized Childhoodjuvenile absence	OSIS Number:						Sex: ☐ Male ☐ Female	
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et-ictal presentation:				•	□ Non-cor	vuisive seizi	,,	
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SEIZURE MEDICATION ADMINISTRATION FORM

Provider Medication Order Form | Office of School Health | School Year 2022-2023

Please return to school nurse. Forms submitted after June 1. may delay processing for new school year.

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.
 - o 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.
- 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.

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 bi	rth:				
School Name/Number:		Borough:	District:				
Parent/Guardian Name (Print):	Parent/Gu	Parent/Guardian's Email:					
Parent/Guardian Signature:		Date Signed:					
Parent/Guardian Address:							
Telephone Numbers: Daytime:	Home	Cell Phone:					
Alternate Emergency Contact:							
Name:	Relationship to Student:	Phone Number:					
	For Office of School Health (OSI	l) Use Only					
OSIS Number:	Received by - Name:	Date):				
☐ 504 ☐ IEP ☐ Other:	Reviewed by - Name:	Date:					
Referred to School 504 Coordinator: \square Yes	□ No						
Services provided by: $\ \square$ Nurse/NP $\ \square$ OSH	Public Health Advisor (for supervised students only)	School Based Health Center					
Signature and Title (RN OR SMD):	nature and Title (RN OR SMD): Date School Notified & Form Sent to DOE Liaison:						
Revisions as per OSH contact with prescrib	ing health care practitioner:	odified					