Yakima School District

MEDICAL AUTHORIZATION FOR EMERGENCY SEIZURE MEDICATION AT SCHOOL

AUTORIZACIÓN MÉDICA PARA ADMINISTRAR MEDICAMENTO DE EMERGENCIA PARA CONVULSIONES EN LA ESCUELA

Student/Estudiante: _____ Birthdate/Fecha de Nacimiento: _____ Grade/Grado: _____

Nurse/Enfermera(o): _____ Phone/Teléfono: _____ School/Escuela: _____ FAX: _____

Parent Section / ***Sección de los padres***

I request medication be on site and that the school nurse or emergency personnel administer the following medication in accordance with healthcare provider instructions. By signing below I authorize that medical information pertaining to Seizures and use of the following medications be exchanged with my student's school nurse in written and verbal forms. I further give permission for these orders to be faxed to the school.
Yo pido que el medicamento esté en la escuela y que la enfermera o personal de emergencia administre el siguiente medicamento de acuerdo con las instrucciones del médico. Al firmar abajo doy autorización para que la información médica pertinente a Convulsiones y al uso de los siguientes medicamentos sea comunicada con la enfermera de la escuela de mi estudiante en forma verbal y escrita. También, doy permiso para que estas órdenes se envíen por fax a la escuela.

I request seizure emergency medication to be at school ☐ Yes/*Si* ☐ No
Solicito tener medicamento de emergencia para convulsiones en la escuela.

I give permission for the nurse to initiate an Emergency Care Plan/504 Plan. ☐ Yes/*Si* ☐ No
Doy permiso para que la enfermera inicie un Plan de Cuidado de Emergencia/Plan 504

_____ _____ _____ _____
Signature/Firma *Date/Fecha* *Phone #1 Números de teléfonos* *Phone #2*

Date of Last Seizure/*Fecha de la última convulsión*: _____ Length of Last Seizure/*Duración de la última convulsión*: _____ Hospitalized/*Hospitalizado*: ☐ No ☐ Yes/Si

Emergency Medication Given?/*¿Se administró medicamento de emergencia?* ☐ No ☐ Yes/Si

Medication Type/*Tipo de medicamento*: ☐ Rectal Diastat/*Diastat Rectal* ☐ Nasal Midazolam/Midazolam Nasal

Describe symptoms previous seizures/*Describa los síntomas previos a la convulsión*: _____

What are your student's triggers?/*¿Cuáles son los causantes de las convulsiones de su estudiante?* _____

STUDENT'S NEUROLOGIST MUST COMPLETE SECTION BELOW
EL NEURÓLOGO DEL ESTUDIANTE DEBE COMPLETAR LA SECCIÓN DE ABAJO

Student's Grand Mal Seizures are: ☐ Controlled, no meds ☐ Controlled, with daily meds ☐ Uncontrolled

Student requires Emergency Seizure medication at school? ☐ No ☐ Yes

Reasoning: _____

Medication Type: ☐ Rectal Diastat ☐ Nasal Midazolam

☐ **NO NURSE REQUIRED ON SITE FULL TIME: (911 TO BE CALLED TO ASSESS AND TREAT)**

Grand Mal Seizure:	
• Muscles tense, body rigid, followed by a temporary loss of consciousness and violent shaking of entire body. May Fall. • **Usually lasts less than 2-5 min** • May have loss of bowel and bladder • Typical to vomit after, roll student to side • Record observations of seizure activity • **If student is diabetic, pregnant, recent head injury or poisoned/has taken drugs call 911!**	1. Note time seizure started and calls for back up! 2. **Call 911 at _____minutes of seizure starting**, ask for Advanced Life Support for an active Grand mal Seizure 3. Call School Nurse (if available) and notify parent/guardian 4. Remain with student until EMS arrives. If medication is on site have medication and orders brought to the student. 5. Clear area around student, do not restrain or put anything in mouth! 6. If breathing stops, start CPR and do not stop until emergency backup arrives!

☐ **NURSE RECOMENDED ON SITE FULL TIME: (student may need to transfer to a school where a nurse is staffed full time; seizure medication at this time is not delegable.)**

Grand Mal Seizures WITH Severe Symptoms (please check):	**Nurse to give emergency medication at _____minutes of Seizure starting. 911 to be called.**
☐ Multiple Recent Grand Mal Seizures ☐ Recent need for emergency Meds ☐ Respiratory suppression with Seizure ☐ **Other:**_____	1. Give _____(Amount) of ☐ Rectal Diastat Or ☐ Nasal Midazolam 2. Notify parent/guardian. Provide emergency care until emergency personnel arrive.

Recommend Medication on bus. ☐ No: 911 to be called if seizure occurs
☐ Yes: 911 protocol ☐ Yes: Other accommodations _____

Recommend student carry this emergency medication to and from school in backpack. ☐ No ☐ Yes

Medication order is valid for duration of school year _____ (includes summer school).

_____ _____
Licensed Health Care Provider Signature *Printed LHCP Name*

_____ _____ _____
Date *Health care provider phone* *Health care provider FAX*