TRAVIS UNIFIED SCHOOL DISTRICT
Authorization for Administration of Emergency Anti-Seizure Medication at School and School Events
Note: First doses of any medication will not be given at school

STUDENT NAME _____ BIRTH DATE _____

TO BE COMPLETED BY AUTHORIZED HEALTHCARE PROVIDER:

List and describe the seizure(s) for which medication will be administered:

Seizure Type	Length	Frequency	Description

In addition to basic seizure first aid, the student should be treated as follows:

Administer medication: Name_____ Dose _____ Route _____ PRN for

Seizure > _____ minutes OR for _____ or more seizures in _____ minutes/hours

Other instructions _____

Call 911:
If a single seizure continues for_____minutes following administration of medication noted above.
If a series/cluster of seizures continues for _____ minutes following administration of medication noted above.
If _____

911 will be called for a student who is Medicated, injured, fails to resume normal breathing or is not arousable following a seizure(s).

Healthcare Provider's Signature _____ Date _____

Healthcare Provider's Name (Print) _____ Phone _____

Address _____

TO BE COMPLETED BY PARENT/GUARDIAN:

My signature below verifies that I am the parent or legal guardian of the pupil named above.

1. I authorize my child to receive the medication as authorized above.
2. I agree to provide and deliver the necessary medication, equipment and supplies to appropriate school staff.
3. I agree to hold the Solano County Office of Education harmless from any and all liability resulting from my child receiving the medication in the manner directed.
4. I consent for the school nurse to communicate with the appropriate school staff when necessary.
5. I consent to the exchange of confidential information regarding my child between Solano County Office of Education and the above named healthcare provider as it relates to the above medication.
6. I agree to notify the school nurse immediately if there is a change in healthcare provider, student's health status or changes in the above authorization.
7. **I agree to notify the school nurse of any administration of emergency anti-seizure medication within 24 hours of the start of the school day.**

Parent/Guardian Signature _____ Date_____

Address _____ Phone _____

Reviewed by School Nurse _____ Date _____

This form must be renewed whenever the prescription changes and at the beginning of each school year.

SN: 4/4/14 cc: CUM/TEACHER/SCHOOL NURSE