Intermediate School District 917
Authorization for Rescue Medication: (Including Vagal Nerve Stimulator)
For Student with Seizures

Student _____ **Birth Date** _____ **School Year** _____
Primary Dx _____ **ICD-10** _____
Dx _____ **ICD-10** _____ **Dx** _____ **ICD-10** _____

Please Note: Form must be completed by *parent and physician* for a rescue medication to be given.

Describe the type of seizure and level of consciousness (no change, altered or loss of) for each seizure type applicable to your child.

- ❑ **Absence (staring)** _____
- ❑ **Complex Partial** _____
- ❑ **Generalized Tonic Clonic or Tonic** _____

Parent/Guardian Authorization

❑ I authorize the school nurse to contact the licensed provider as needed concerning the childôs health needs, the actions of the medication(s), and clarify administration instructions.

Provider/Clinic _____ Phone # _____ Fax # _____

- I understand that I am to furnish all necessary medications.
- I understand that parent/guardian authorization is required for any prescriptive or non-prescriptive medication to be given at school. Prescriptive medications that are taken for more than (14) calendar days must have a physician or licensed provider authorization. Physician authorization may be required for a prescriptive medication PRIOR to administration at school based on the discretion of the Licensed School Nurse (LSN).
- Non-prescriptive medications may also require physician approval at the discretion of the LSN.
- Students are prohibited from using a medication, including an inhaler that is not authorized for their personal use.
- I will notify the school immediately if my childôs health status changes, or there is a change or cancellation of the medications.
- I understand all medications must be provided with an accurately labeled prescription container**. (Please ask your pharmacist for the medication to be divided into two bottles completely labeled, one for 'school,' one for 'home.')** Non-prescriptive medications provided by the parent must be in an original container with label and directions.
- I have read this *Parent/Guardian Authorization* section and agree to the instructions it provides.
- The procedure(s) may be performed by school personnel trained and supervised by a Licensed School Nurse.

Parent/Guardian Signature _____ **Date** _____

PHYSICIAN AUTHORIZATION REQUIRED

Does the student have a Vagal Nerve Stimulator (VNS)? _____Yes _____No If yes, describe magnet use

_____

Rescue MEDICATION _____ **DOSE** _____ **ROUTE** _____

(Type of seizure): _____ **lasting longer than** _____ **minutes.**

❑ Administer medication per package/drug insert, or the following instructions _____

_____

❑ The following complications may occur from this medication _____

CALL 911 if a single _____ **(type of seizure) lasts longer than** _____ **minutes, or cluster of seizures lasting longer than** _____ **minutes, AFTER administration of rescue medication.**

CALL 911 for respiratory compromise without adequate recovery and or concern that; the seizure is unusual and that student does not regain consciousness or seizure occurs in water.

Physician Signature _____ **Date** _____

For office use only:
LSN Signature _____ Date _____
Name of Staff Routing _____ Date _____
Please check off who was routed this form _____Student File _____IEP Manager _____917 LSN _____Building Nurse