Naperville 203
Community Unit School District

PHYSICIAN'S ORDER FOR SEIZURE MANAGEMENT

Student's Name: _____ Birthdate: _____ Grade: _____

Address: _____ Phone: _____ School: _____

TO BE COMPLETED BY THE PHYSICIAN

TYPE OF SEIZURE(S) student experiences: _____

DESCRIPTION of seizure presentation for this student: _____

_____

PE Modifications/Special Instructions (swimming, rock climbing, heights, etc.): _____

_____

If student has a seizure described above, initiate the following procedure(s):

☐ No emergency medication required. Follow basic seizure first aid.
☐ Student has VNS. Instructions for VNS magnet use: _____
☐ Give emergency medication below for a seizure that lasts longer than _____ minutes.
☐ Give emergency medication below for a cluster of seizures that lasts longer than _____minutes.
☐ Other: _____

Seizure Medication: _____ Dosage: _____ Route: _____

Frequency: _____ Side Effects: _____

Duration of Order: __Current School Year___ or other: (specify duration) _____

X_____
PHYSICIAN/LICENSED PRESCRIBER'S SIGNATURE PRINTED NAME DATE

OFFICE PHONE NUMBER: _____ OFFICE FAX NUMBER: _____

PARENT/GUARDIAN AUTHORIZATION FOR SCHOOL MEDICATION

I hereby request that Naperville School District 203 employees administer or supervise the administration of medication in accordance with the routine described under the Guidelines for the Administration of Medication in Naperville School District 203. **I understand that I will need to pick up unused doses of the medication at the end of the school year. Unused medication will not be sent home with my child and will be destroyed if not picked up by the last day of school.**

I hereby release Naperville Community Unit School District 203 and any of its agents, employees administrators or other parties (hereinafter, the "District") from any liability for any injury or harm which is suffered by (student's name) _____ as a result of our District's agreement to honor this request. I agree to indemnify and hold the District harmless from any legal action or other attempts to acquire compensation, including damages and legal and medical fees, from the District whenever the District has acted in accordance with the information provided by my child's physician.

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

Please return this form with your child's medication to the school health office.