

## 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.**