Mid-Buchanan R-V School District
FAX: 816-238-2484

Long-term medication may be given by district personnel provided that the prescribing physician completes this district medication permission request for:

Student's Name: _____ School: _____ Date of Birth: _____

THE FOLLOWING SECTION IS TO BE COMPLETED BY THE PHYSICIAN

_____

Physician's Name Address Telephone

Name of Medicine: _____Dosage: _____ Form: _____

Diagnosis for which medication is to be given: _____

If medication is to be given daily, at what time? _____

If medication is to be given, "When Needed", describe indications: _____

_____

How soon can it be repeated? _____

Is the student authorized to carry and/or administer medication or bronchodilators to him/herself?

_____YES _____ NO

List significant side effects: _____

Length of time this treatment is recommended: _____

Other Information: _____

Medications for emergency health conditions must with complete instructions for administering the medication.

Date: _____ Physician Signature: _____

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THE FOLLOWING IS TO BE COMPLETED BY THE PARENT

I hereby give permission for _____ to take the above prescription and/or medication at school as ordered. I understand that it is my responsibility to furnish the medication. I further understand that the above information will be completed by the attending physician or dentist before any medication will be administered, and the medicine will be administered in accordance to their written instructions.

Date: _____ Signature of Parent/Guardian:_____

NOTE: The medication is to be brought to the school in the prescription container appropriately labeled by the pharmacy or physician, stating name of medication, the dosage, time to be administered and the name of the student.

SEIZURE ACTION PLAN (SAP)

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Name: _____ Birth Date: _____

Address: _____ Phone: _____

Emergency Contact/Relationship _____ Phone: _____

Seizure Information

Seizure Type	How Long It Lasts	How Often	What Happens

How to respond to a seizure (check all that apply) ☑

- ☐ First aid – **Stay. Safe. Side.**
- ☐ Give rescue therapy according to SAP
- ☐ Notify emergency contact
- ☐ Notify emergency contact at _____
- ☐ Call 911 for transport to _____
- ☐ Other _____

First aid for any seizure

- ☐ **STAY** calm, keep calm, **begin timing seizure**
- ☐ Keep me **SAFE** – remove harmful objects, don't restrain, protect head
- ☐ **SIDE** – turn on side if not awake, keep airway clear, don't put objects in mouth
- ☐ **STAY** until recovered from seizure
- ☐ Swipe magnet for VNS
- ☐ Write down what happens _____
- ☐ Other _____

When to call 911

- ☐ Seizure with loss of consciousness longer than 5 minutes, not responding to rescue med if available
- ☐ Repeated seizures longer than 10 minutes, no recovery between them, not responding to rescue med if available
- ☐ Difficulty breathing after seizure
- ☐ Serious injury occurs or suspected, seizure in water

When to call your provider first

- ☐ Change in seizure type, number or pattern
- ☐ Person does not return to usual behavior (i.e., confused for a long period)
- ☐ First time seizure that stops on its' own
- ☐ Other medical problems or pregnancy need to be checked

When **rescue therapy** may be needed:

WHEN AND WHAT TO DO

If seizure (cluster, # or length) _____

Name of Med/Rx _____ How much to give (dose) _____

How to give _____

If seizure (cluster, # or length) _____

Name of Med/Rx _____ How much to give (dose) _____

How to give _____

If seizure (cluster, # or length) _____

Name of Med/Rx _____ How much to give (dose) _____

How to give _____

Care after seizure

What type of help is needed? (describe) _____

When is person able to resume usual activity? _____

Special instructions

First Responders: _____

_____

Emergency Department: _____

_____

Daily seizure medicine

Medicine Name	Total Daily Amount	Amount of Tab/Liquid	How Taken (time of each dose and how much)

Other information

Triggers: _____

Important Medical History _____

Allergies _____

Epilepsy Surgery (type, date, side effects) _____

Device: ☐ VNS ☐ RNS ☐ DBS Date Implanted _____

Diet Therapy ☐ Ketogenic ☐ Low Glycemic ☐ Modified Atkins ☐ Other (describe) _____

Special Instructions: _____

_____

Health care contacts

Epilepsy Provider: _____ Phone: _____

Primary Care: _____ Phone: _____

Preferred Hospital: _____ Phone: _____

Pharmacy: _____ Phone: _____

My signature _____ Date _____

Provider signature _____ Date _____

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