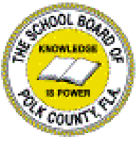

SEIZURE EMERGENCY AUTHORIZATION FOR MEDICATION/TREATMENT

School Board of Polk County

(Must be filled out completely and signed by physician/healthcare provider.)

Student's Name____ **Birth Date**_____________ **Grade** _____ **School Year**________________

Parent/Guardian: ____ **Home ph. # (1)** ________ **ph.#(2)** ___________ **ph.#(3)**____________

Physician: ____ **Physician's phone #** ________________ **Age diagnosed:** _______________

Seizure Triggers: ____
____

Seizure Aura or Warning Signs (describe): ____

Seizure Type(s): ____ **Length:** _____________ **Frequency:** _________________

A "seizure emergency" for this student is described as: ____

Student's Response after a seizure: ____

Student-specific Seizure Emergency Protocol (Physician and parent signature required below to administer medication):

☐ **Notify parent/guardian or emergency contact** ☐ **Call 911 for transport to:** ____

☐ **Administer Diazepam/ Diastat Rectal Gel _______mg: Give _______mg per rectum for seizures lasting more than ______minutes; or in clusters of more than __________seizures in 1 hour. Call 911 if the seizures do not stop _______minutes after Diastat given or if child has problems breathing during or after a seizure.**
Note: According to Polk County School Board policy, a licensed nurse is required for Diastat administration.

OR

☐ **Administer Clonazepam/Klonopin (orally disintegrating) tablets: _______mg: Give _______mg orally for seizures lasting more than ______minutes; or in clusters of more than __________seizures in 1 hour. Call 911 if the seizures do not stop _______minutes after given or if child has problems breathing during or after a seizure.**

☐ **Vagus Nerve Stimulator?** If yes, describe magnet use: ____
____
____

☐ Call 911 if still seizing after ____swipes. ☐ Wait ___ minutes between swipes. ☐ Give _____swipes before any emergency medication.

Special Considerations and Precautions (regarding school activities, sports, field trips, helmet use, etc.): ________________
____

I hereby authorize the above named physician and Polk County Schools/Florida Department of Health in Polk County staff to reciprocally release verbal, written, faxed, or electronic student health information regarding the above named child for the purpose of giving necessary medication or treatment while at school. I understand Polk County School District protects and secures the privacy of student health information as required by federal and state law and in all forms of records, including, but not limited to, those that are oral, written, faxed or electronic.
I request that my child be assisted in taking the medication or treatment described above at school by authorized persons as permitted by me and my physician.

Parent/Guardian Signature: ____**Date:**_____________

Physician's/Mid-Level Practitioner's Signature: ____ **Date:** _____________

School Health Registered Nurse Signature: ____ **Date:** _____________

911 Must Be Called When:

- √ First known seizure
- √ Any seizure lasting more than 5 minutes
- √ Any seizure followed by another, without a period of consciousness in between
- √ A student with diabetes who has a seizure
- √ A pregnant woman who has a seizure
- √ Head injury during a seizure
- √ Student has breathing difficulties or a seizure in water
- √ Parent requests an ambulance be called

Place Physician's Office Stamp Here