Form 4: Physician Authorization for Administration of Emergency Anti-Seizure Medication at School and School-sponsored Events

Pupil:	DOB:	Date:
School:	Teacher/Rm:	Grade:
Medical office:	Patient Identification #:	

TO PHYSICIAN:

- Please provide the mandatory specific instructions and authorization to assist our school staff in emergency anti-seizure medication administration as needed in school settings.
- Emergency services will be called and parent/guardian contacted following emergency anti-seizure medication administration in accordance with Education Code Section 49414.7, which does not require that the pupil be transported to an emergency room. Emergency medical services protocol may require a parent/guardian to be present to avoid transport to emergency room. Emergency services may also be called according to legal requirement/school district policy and standard school emergency procedures. These requirements and/or policies may include: (a) emergency anti-seizure medication procedure may only be implemented for pupils who have been given the medication previously and without complications; (b) if emergency anti-seizure medication is administered to the pupil for the first time at school.

	emergency anti-seizure medication is administered to the pupil for the first time at school.
1.	Medication—Name and Purpose:
	Dosage:
	Method of Administration:
	Frequency of Administration:
	☐ The frequency of anti-seizure medication administration must be agreed upon by parent/guardian and physician and discussed with the credentialed school nurse, prior to administration.
2.	Specific description of seizure symptoms (including, but not limited to, frequency, type, or length of seizures) that identify when the administration of an emergency anti-seizure medication is necessary:
3.	Circumstances under which the medication is to be administered:
4.	Date when emergency anti-seizure medication was last administered:
5.	Other seizure medications prescribed for the pupil:
6.	Potential adverse reactions and recommended mitigation actions:
7.	Protocol for observing pupil after a seizure (including, but not limited to, whether the pupil should rest in the school office, whether the pupil may return to class and length of time pupil should be under direct observation):

Form 4: Parent Consent and Physician Authorization for Administration of Anti-Seizure Medication

Pupil:	DOB:	Date:	
8. In accordance with district/school's standard seizure protocol, if emergency anti-seizure medication is administered minutes (30, if this section is left blank) prior to busing, pupil will not be transported by bus unless authorized by the school nurse.			
 The parent is to provide written notific emergency anti-seizure medication add the start of a school day. 			
If parent notifies the district/school of modified as follows: (describe change parent administration notification as defined as follows:	e, if any, to the above administra	_	
<u>PHYSIC</u>	IAN AND PARENT SIGNAT	<u>URES</u>	
Authorization and Consent for Emery My signature below provides authorization will be implemented in accordance with shealthcare services may be performed by supervision provided by the school nurse indicated, I will provide new written authorization I verify that this	on for the written orders on page state laws and regulations. I und nonmedical volunteer school per This authorization is for a max orization. Authorizations may be	e 1. I understand that all procedures erstand that specialized physical ersonnel under the training and imum of one year. If changes are	
(MD Initials) without complic			
*Authorized Healthcare Provider Signa			
Authorized Healthcare Provider Name Address Phone:	(PRINT):	Zip	
*Nurse Practitioner, Nurse Midwife, Pl	•		
Supervising Physician Name	Address	Phone	
Parent Consent for Emergency	Anti-Seizure Medication Adm	inistration in School Settings	
I (we) the undersigned, the parent(s)/guar Medication be administered to my (our) of 1. provide the necessary medication(s), equ 2. notify the school nurse if there is a change	child in accordance with state lar ipment, supplies. the in child's health status or attending	ws and regulations. I (we) will: ng authorized healthcare provider.	
 notify the school nurse immediately and authorization. I (we) give consent for the school nurse to necessary. 			
I (we) understand that I (we) will be prov Plan(IHP).	ided a copy of my child's comp	leted Individualized Healthcare	
Parent(s)/Guardian(s) Signature (1)	(2)	Date	
Reviewed by the school nurse (signature	e)	Date	
School Nurse has informed principal ab			



<u>DAVIS JOINT UNIFIED SCHOOL DISTRICT</u> MEDICATION ASSISTANCE AUTHORIZATION

Student Name:	SIS#:	D.O	.B	
Address:				
School:		Grade: Teacher:_		
Parent/Guardian Phone: Home:	Work:	Cell:	Emergency:	

IMPORTANT INFORMATION

In accordance with California Education Code Section 49423, Section 504 of the Rehabilitation Act of 1973, and Title II of the Americans with Disabilities Act of 1990, students who have a Medical Disability for which a physician has prescribed Medication to be taken during the school day, whether of limited or permanent duration, are entitled to seek assistance from the District in meeting their Medication needs when the student is under the District's care, custody, or control, including while the student is on field trips, sporting events, and other off-campus District-sponsored activities. **Except for personal asthma inhalers, personal epi-pens, and glucagon kits, a student may not independently possess Medication during the school day or while on District property**. Due to health and safety concerns, including the potential theft of the Medication or the potential for improper sharing/use of the Medication by other students who may then suffer unexpected allergic or other negative reactions, **there are no exceptions to this requirement**. A student personally possessing Medication, misusing Medication, or providing Medication to another student, may face discipline.

<u>Medication</u>, means currently (unexpired) prescribed Medications, as well as over-the-counter remedies (such as aspirin, decongestant, eye drops) and nutritional/herbal supplements. Because several over-the-counter medications can present safety or health hazards to others, <u>all Medications are subject to the following rules and regulations</u>.

<u>Medical Disability</u>, means any mental or physical condition limiting a student's ability to engage in major life activities (such as eating, breathing, hearing, speaking, learning, or performing self-care) or which otherwise is subject to a medical disability or condition for which Medication has been prescribed or recommended by a physician.

<u>Medication Assistance</u>, means the storage of Medication, or the providing of Medication to a student in accordance with a physician's written instructions or directives, when the child presents himself/herself at the agreed time, or in response to urgent or emergency circumstances. As permitted by law, assistance may be provided by a District employee other than a nurse or licensed or trained medical care provider. Any emergency assistance provided to a student will be promptly brought to the attention of the parent/guardian. All additional reports/reporting of emergency Assistance will be undertaken in keeping with governing laws and District policies and procedures.

Before Medication Assistance can be provided, even if the student has an Individualized Education Plan ("IEP") or a "504 Plan," this Medication Assistance Authorization form ("Authorization") must be executed by at least one parent/legal guardian <u>and</u> the student's duly authorized health care provider. <u>A new Authorization is required at the beginning of each school year and any time there is a change in Medication directives (such as change in Medication, dosage, timing, or <u>frequency</u>). The parent/legal guardian must immediately notify the District of any change in Medication directives.</u>

All Medication must be provided to the District by a parent/legal guardian, with the District storing the Medication and dispensing it in compliance with the Medication directive. All medication supplied to the District must be in its original labeled form (i.e., in the original prescription bottle, sealed package, etc.) as received from the physician, pharmacist, or store. Until the District receives an updated Authorization, signed by the parent/legal guardian and health care provider, the District will continue to provide the provided Medication, and provide Medication Assistance according to an existing Authorization, unless (a) there is evidence the student's health may be endangered by the continued use of the former Medication directive, or (b) the parent/legal guardian provides a written statement that Medication Assistance is to cease or be suspended until the new Authorization can be provided. In such situations, the parent/legal guardian will need to provide the Medication Assistance to the student at agreed times during the school day in a safe and appropriate manner that does not unduly disrupt the educational environment.

464878.1 July 2017



<u>DAVIS JOINT UNIFIED SCHOOL DISTRICT</u> MEDICATION ASSISTANCE AUTHORIZATION

PARENT/GUARDIAN AUTHORIZATION

I have read, understand, and agree to be bound by the rights and obligations contained in the Important Information section of this Authorization. I request that Medication Assistance be provided to my Student.

The Student understands his/her obligations described in the Important Information section above, including the need to ensure he/she complies with the directions for receiving Medication Assistance (i.e., coming to the school or nurse's office each day, at the same time, without need for a District employee to attempt to locate them) and the policy against his/her personal possession or sharing of Medication (except for asthma inhalers, epi-pens, and glucagon kits). I understand that if the Student fails to meet these obligations that he/she may face discipline and/or this Authorization may be revoked.

Unless required by law, I understand there is no guarantee that Medication Assistance will be performed by a nurse or licensed health care provider, although the District will take reasonable steps to ensure that the District employee providing Assistance has received training that complies with all legal requirements. As a partner with the District in protecting the Student's health and safety, I will work with school staff regarding Medication Assistance issues, including Medication Assistance issues when the Student is expected to be involved in off-campus District-sponsored activities. I will also timely advise the District of any change in Medication directives. It is my responsibility to obtain a new Authorization form, signed by a licensed health care provider, when there is a change in Medication directives. I will comply with my responsibilities described above should those Medication directives change.

below to discuss the sinformation to the Dis	student's medical and/or Medi strict as may be necessary to ca	ication information, I authorize	authorize the District and the health care provider the health care provider to provide any additional I authorize the disclosure of this information to all with, the Student.		
Date	Signature Parent/O	Guardian	Printed Name Parent/Guardian		
prescribed, or more ex	(student name) is under		<u>DN</u> et the following: (If more than two medications are rate signed sheet noting the additional information)		
1st Med. Name	Dosage	Method of Admin.	Duration (date/week/month/until discontinued)		
	☐ Regular (if yes, add Interval/Time of Day)	☐ Emergency basis (Must Describe Symptoms/Triggers)	☐ As Needed (Must Describe Symptoms/Triggers)		
Student capable of self-administering? □Yes □No		Student may/should carry medication? Yes No (applies only to inhalers/epi-pens/glucagon)			
Must a District employ	vee have special training/experience		es \square No (If yes, describe the training/experience).		
Post Assistance Care/P	Potential Adverse Reactions/Follow	w-up/Emergency Care:			
2st Med. Name	Dosage	Method of Admin.	Duration (date/week/month/until discontinued)		
	☐ Regular (if yes, add Interval/Time of Day)	☐ Emergency basis (Must Describe Symptoms/Triggers)	☐ As Needed (Must Describe Symptoms/Triggers)		
Student capable of self-administering? □Yes □No		Student may/should carry medication? Yes No (applies only to inhalers/epi-pens/glucagon)			
Must a District employ	vee have special training/experience	ce before providing assistance? \(\sigma\)Ye	es \square No (If yes, describe the training/experience).		
Post Assistance Care/P	Potential Adverse Reactions Requi	ring Follow-up/Emergency Care:			
Additional Remarks	s/Directions				
		Medical Lic	cense No.		
Address		Telephone			
Physician's Signatur	re	Date	Date		

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