

SEIZURE MEDICATION AUTHORIZATION AND EMERGENCY ACTION PLAN FOR CMS STUDENTS

If Submitting by Fax (School Nurse Fax Number):		
Student's Name (Print):	Student's Date of Birth:	For School Use Only
		Date Received/Receiver's Signature:
		Medication Received? <input type="checkbox"/> yes <input type="checkbox"/> no
School's Name/Phone Number:	Teacher/Grade:	Date Approved/Nurse's Signature
		Entered in EHR? <input type="checkbox"/> yes <input type="checkbox"/> no
Preferred Hospital:	Emergency contact and number:	

In order to help protect each student's health, parent/legal guardian consent and written authorization from a licensed healthcare provider authorized to practice in North Carolina with prescribing rights are required when it is necessary for students to receive prescription or over-the-counter medications in Charlotte-Mecklenburg Schools. Additional documentation may be required for some medications (examples: research medications, medications with potential for immediate serious side effects). Some medications may not be suitable for a school setting. Contact the School Nurse if you have questions.

SECTION 1: LICENSED HEALTHCARE PROVIDER AUTHORIZATION (Please write legibly; use lay terms.)

Medication (generic/brand):	Dose:	Route:	Administer if seizure is longer than _____ minutes in duration.
Medication instructions:			

SEIZURE Emergency Action Plan:

- Observe seizure activity and time the seizure. Assist student to side lying position, loosen clothing around neck, remove glasses and clear area. Remain with the student. Call front office for the school nurse and First Responder.
- Administer medication as directed above and document on the student's medication administration record (MAR).
- Assess student for specific behaviors and movements during the seizure and complete the seizure flow sheet.
- Notify parent/guardian. Student must be picked up from school.
- Observe for decreased breathing or heart rate, change in color, head injury at time of seizure, duration and number of seizures. Begin artificial breathing if indicated. Nurse will monitor vital signs.
- Other information:
- Call 911 if: _____

In my professional opinion, it is necessary for this student to receive this medication during school hours in order to maintain/improve health and school attendance. Please notify the principal and/or school nurse and parents/guardians if there are any problems.

Stamp/Print/Type Healthcare Provider's Name & Address:	Office Phone:	Healthcare Provider Signature:	Date:
	Office Fax:		

SECTION 2: PARENT / LEGAL GUARDIAN CONSENT

I understand that: No medication will be given at school until this authorization has been received and verified by a School Nurse. A separate form is required for each medication. New authorization forms are required at the beginning of each school year, when the dose or directions change, and when a new medication is prescribed. It is my responsibility to supply the medication. Each medication must be in an appropriately labeled original container from the pharmacy or healthcare provider's office (many pharmacies will provide an extra container for school use upon request). Information about this medication and my child's health may be shared with other school staff or agents of the school if needed to help assure my child's safety and success at school.

- I give permission for my child to receive the medication described above during school hours.
- I give permission for the school nurse to contact the healthcare provider who prescribed the medication and the pharmacy where the prescription was filled to discuss this medication and my child's health if needed.
- I give permission for the healthcare provider, pharmacist and their staff to provide information to the school nurse about this medication and my child's health.
- On behalf of my child, I absolve the Charlotte-Mecklenburg Board of Education, their agents and employees from any and all liability whatsoever that may result from my child taking this medication at school.
- I have reviewed this order and give my permission for the School Health Nurse to train school personnel to follow this order.

Parent/Legal Guardian Signature:	Date:	Phone Numbers (mobile, work, home):
Parent/Legal Guardian (Print Name):		

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SECTION 3: Authorization for Self- Medication by CMS Students

Student's Name	Student's Date of Birth	Name of Medication

CMS ELIGIBILITY REQUIREMENTS FOR SELF-MEDICATION

Students with chronic conditions such as asthma, diabetes, severe allergies and those who require frequent doses of non-prescription products, may be eligible to self-medicate. Self-administration of a controlled substance will be considered in rare instances where potentially harmful medical episodes may occur. For self-medication, students: 1) must be mentally, emotionally, and physically capable of self-administering medication, 2) must have been instructed in proper use and safe-keeping of their medications, 3) must demonstrate mature and responsible behavior using their medication 4) must keep their medication secure on their own person or in some other manner agreed upon with the school nurse and the school administration, and 5) must not share medication with or display to other students. The privilege of being allowed to self-medicate may be taken away if there is any just cause. Failure to follow CMS policies and regulations may result in disciplinary actions as noted in the Student Code of Conduct. The CMS Board of Education, its designees and agents, do not assume responsibility for self-medication by students. Additional details are noted in CMS Policy JLCD/Regulation JLCD-R.

HEALTHCARE PROVIDER

The student named above meets the CMS eligibility requirements for self-medication. This student is capable of, has been instructed on the procedures for and has demonstrated the skill to self-administer this medication as directed in Section 1 of this form. This student will not require adult supervision while taking this medication.

Check applicable items below:

- This medication is a controlled substance.
- Please allow this student to self-administer this medication while at school during school hours.
- This student should carry this medication with him/her at all times during the school day, while at school-sponsored events, or while in transit to or from school or school-sponsored activities.

Healthcare Provider Signature:	Date:
Healthcare Provider (Print Name):	

PARENT/LEGAL GUARDIAN

My child is capable of self-medicating and meets the CMS eligibility requirements. I give consent to the Charlotte-Mecklenburg Schools to allow my child to self-administer this medication at school. I understand that my child and I assume responsibility for the proper use and safekeeping of this medication. If this medication is for a life-threatening emergency such as anaphylaxis or asthma, I agree to provide a backup supply of the medication to be kept at school in a location to which my child has immediate access to assure the medication is available if needed. I release the Charlotte-Mecklenburg Board of Education, their agents and employees from any and all liability whatsoever that may result from my child carrying or taking this medication at school. I understand that information about this medication and my child's health may be shared with other school staff and agents of the school to help assure my child's safety and success at school. The school nurse may contact the healthcare provider who prescribed the medication and the pharmacy where the prescription was filled to discuss this medication and my child's health.

Parent/Legal Guardian Signature:	Date:
Parent/Legal Guardian (Print Name):	

STUDENT

I am capable of taking this medication on my own. I agree to take this medication as ordered. I will keep it safe and out of the sight of others when I am not using it. I will not let others hold or use my medication or medical supplies. I understand that I will be disciplined under the CMS Student Code of Conduct if I abuse the privilege of being allowed to self-medicate while at school or school sponsored activities. I understand that I may lose the privilege of self-administering my medication if I do not follow these rules.

Student Signature:	Date:
Student (Print Name):	

SCHOOL NURSE

I have reviewed this request and acknowledge that this student has demonstrated the skill level to self-administer this medication. I have informed this student that he or she must tell an appropriate staff member whenever he or she has used the medication at school.

Nurse Signature:	Date:
Nurse (Print Name):	

PRINCIPAL / DESIGNEE

I have reviewed this request and approve this student for self-administering this medication.

Principal/Designee Signature:	Date:
Principal/Designee (Print Name):	