Attach student photo here

# SEIZURE MEDICATION ADMINISTRATION FORM

Provider Medication Order Form I Office of School Health I School Year **2025-2026**

Please return to School Nurse/School Based Health Center. Forms submitted after June 1st may delay processing for new school year.

Student Last Name: _____ First Name: _____ Middle: _____ Date of Birth: _____

Sex: ☐ Male ☐ Female OSIS Number: _____ Grade: _____ Class: _____ DOE District: _____

School (include name, number, address, and borough): _____

**HEALTH CARE PRACTITIONERS COMPLETE BELOW**

**Diagnosis/Seizure Type:**

☐ Localization related (focal) epilepsy ☐ Primary generalized ☐ Secondary generalized ☐ Childhood/juvenile absence

☐ Myoclonic ☐ Infantile spasms ☐ Non-convulsive seizures ☐ Other (please describe below)

| Seizure Type | Duration | Frequency | Presentation/Description | Triggers/Warning Signs/Pre-Ictal Phase |
|---|---|---|---|---|
| | | | | |
| | | | | |

**Post-ictal presentation:**

**Seizure History:** Describe history & most recent episode (date, trigger, pattern, duration, treatment, hospitalization, ED visits, etc.):

Status Epilepticus? ☐ No ☐ Yes Has student had surgery for epilepsy? ☐ No ☐ Yes - Date: _____ Well Controlled? ☐ No ☐ Yes

## TREATMENT PROTOCOL DURING SCHOOL:

### A. In-School Medications

**Student Skill Level** (select the most appropriate option)

☐ Nurse-Dependent Student: nurse must administer

☐ Supervised Student: student self-administers, under adult supervision

☐ Independent Student: student Is self-carry/self-administer

☐ I attest student demonstrated ability to self-administer the prescribed medication effectively during school, field trips, and school sponsored events - Practitioner's Initials: _____

| Name of Medication | Concentration/ Formulation | Dose | Route | Frequency or Time | Side Effects/Specific Instructions |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |

### B. Emergency Medication(s) (list in order of administration) [Nurse must administer] ; CALL 911 immediately after administration

| Name of Medication | Concentration/ Preparation | Dose | Route | Administer After | Side Effects/Specific Instructions |
|---|---|---|---|---|---|
| ☐ diazepam | | | | min | |
| ☐ midazolam | | | | min | |
| | | | | | |

**C. Does student have a Vagal Nerve Stimulator (VNS)? (any trained adult can administer)** ☐ No ☐ Yes , If YES, describe magnet use:

☐ Swipe magnet ☐ immediately ☐ within _____ min; if seizure continues, repeat after _____ min _____ times;

Give emergency medication after _____ min and call 911

**Activities:**

Adaptive/protective equipment (e.g., helmet) used? ☐ No ☐ Yes

Gym/physical activity participation restrictions? ☐ No ☐ Yes - If YES, please complete the Medical Request for Accommodations Form

☐ **Other:** _____

☐ **504 accommodations requested (e.g., supervision for swimming)?** ☐ **Yes (attach form)** ☐ No

| Home Medication(s) ☐ None | Dosage, Route, Directions | Side Effects/Specific Instructions |
|---|---|---|
| | | |
| | | |

Other special instructions

**Health Care Practitioner**

Last Name (Print): _____ First Name: _____ (Please Check one): ☐ MD ☐ DO ☐ NP ☐ PA

Signature: _____ Date: _____ NYS License # (Required): _____ NPI #: _____

Address: _____ E-mail address: _____

Tel. No: _____ FAX No: _____ Cell Phone: _____

INCOMPLETE PRACTITIONER INFORMATION WILL DELAY IMPLEMENTATION OF MEDICATION ORDERS

FORMS CANNOT BE COMPLETED BY A RESIDENT

Rev 3/25

**PARENTS MUST SIGN PAGE 2 →**

# SEIZURE MEDICATION ADMINISTRATION FORM

Provider Medication Order Form | Office of School Health | School Year **2025-2026**

**Please return to School Nurse/School Based Health Center. Forms submitted after June 1st may delay processing for new school year.**

**PARENTS/GUARDIANS: READ, COMPLETE, AND SIGN. BY SIGNING BELOW, I AGREE TO THE FOLLOWING:**

1. I consent to my child's medicine being stored and given at school based on directions from my child's health care practitioner. I also consent to any equipment needed for my child's medicine being stored and used at school.

2. **I understand that:**

- I must give the school nurse/school based health center (SBHC) provider my child's medicine and equipment.
- **All prescription and "over-the-counter" medicine** I **give the school must be new, unopened, and in the original bottle or box.** I will get another medicine for my child to use when he or she is not in school or is on a school trip.
    - o Prescription medicine must have the **original** pharmacy label on the box or bottle. Label must include: 1) my child's name, 2) pharmacy name and phone number, 3) my child's health care practitioner's name, 4) date, 5) number of refills, 6) name of medicine, 7) dosage, 8) when to take the medicine, 9) how to take the medicine and 10) any other directions.
- I must **immediately** tell the school nurse/SBHC provider about any change in my child's medicine or the health care practitioner's instructions.
- **No student is allowed to carry or give him or herself controlled substances.**
- The Office of School Health (OSH) and its agents involved in providing the above health service(s) to my child are relying on the accuracy of the information in this form.
- By signing this medication administration form (MAF), OSH may provide health services to my child. These services may include a clinical assessment or a physical exam by an OSH health care practitioner or nurse.
- The medication order in this MAF expires at the end of my child's school year, which may include the summer session, or when I give the school nurse/SBHC provider a new MAF (whichever is earlier). When this medication order expires, I will give my child's school nurse/ SBHC provider a new MAF written by my child's health care practitioner.
- This form represents my consent and request for the medication services described on this form, and may be sent directly to OSH. It is not an agreement by OSH to provide the requested services. If OSH decides to provide these services, my child may also need a Section 504 Accommodation Plan. This plan will be completed by the school.
- OSH may obtain any other information they think is needed about my child's medical condition, medication or treatment. OSH may obtain this information from any health care practitioner, nurse, or pharmacist who has given my child health services.
- I understand that emergency seizure medications, including intranasal medications, can only be administered by a nurse or other licensed medical provider according to New York State regulations.

**NOTE: It is preferred that you send medication and equipment for your child on a school trip day and for off-site school activities.**

**FOR SELF-ADMINISTRATION OF NON-EMERGENCY MEDICATIONS (INDEPENDENT STUDENTS ONLY):**

- I certify/confirm that my child has been fully trained and can take medicine on his or her own. I consent to my child carrying, storing and giving him or herself the medicine prescribed on this form in school and on trips. I am responsible for giving my child this medicine in bottles or boxes as described above. I am also responsible for monitoring my child's medication use, and for all results of my child's use of this medicine in school. The school nurse or SBHC provider will confirm my child's ability to carry and give him or herself medicine. I also agree to give the school "back up" medicine in a clearly labeled box or bottle.

**Student** Last Name: _____ First Name: _____ MI: _____ Date of birth: _____

**School** Name/Number: _____ Borough: _____ District: _____

**Parent/Guardian** Name (Print): _____ Parent/Guardian's Email: _____

**Parent/Guardian** Signature: _____ Date Signed: _____

**Parent/Guardian** Address: _____

Telephone Numbers: Daytime: _____ Home_____ Cell Phone: _____

**Alternate Emergency Contact:**

Name: _____ Relationship to Student: _____ Phone Number:_____

## For Office of School Health (OSH) Use Only

**OSIS Number:** _____ **Received by -** Name: _____ Date: _____

☐ 504 ☐IEP ☐ Other: _____ **Reviewed by -** Name: _____ Date: _____

**Referred to School 504 Coordinator:** ☐ Yes ☐ No

**Services provided by:** ☐ Nurse/NP ☐ OSH Public Health Advisor (for supervised students only) ☐ School Based Health Center

**Signature and Title** (RN OR SMD):_____ **Date School Notified & Form Sent to DOE Liaison**: _____

**Revisions as per OSH contact with prescribing health care practitioner:** ☐ Clarified ☐ Modified