Provider Order for Seizure Medication Authorization

Student's Name: _____ DOB: _____

School: _____Grade: _____ School Year: _____

Medication: _____ **Dose:** _____ **Route:** _____

Medication: _____ **Dose:** _____ **Route:** _____

Medication Expiration Dates:

CHECK YOUR SPECIFIC TREATMENT ORDERS BELOW:

1. **INDICATION FOR ADMINISTRATION OF EMERGENCY SEIZURE MEDICATION:**

   - ☐ Generalized seizure of _____ minutes.
   - ☐ Two or more consecutive seizures (without a period of consciousness between) that last 5 minutes or more.
   - ☐ Other: _____

2. **911 NOTIFICATION--**911 will be notified anytime Diastat is administered unless otherwise ordered by the physician. Please document here if 911 is not to be called:

   _____

3. **FREQUENCY OF DIASTAT ADMINISTRATION:**

   - ☐ May only be administered once.*
   - ☐ A second dose may be administered _____hours after a first dose.**
   - ☐ May be administered _____times every _____ (specify a number of hours or days).**

   **911 will be called if a student has a second seizure on the same day:
   -- before the stated time interval for a second dose has passed,
   -- if no second dose of diastat has been ordered,
   -- if no second dose of diastat is on-hand.

Name of Physician (please print): _____

Address: _____

Phone: _____ Fax: _____

Physician Signature: _____ Date: _____

I hereby authorize Arlington Department of Human Services and Arlington Public Schools personnel, including unlicensed persons, to give the medication described above as directed by this authorization. I agree to release, indemnify, and hold harmless Arlington Public Schools, Arlington Department of Human Services, Arlington County, and any of its officers, staff members, or agents from any lawsuit, claim, expense, demand, or action, etc., against them arising out of or in connection with assisting this student by administration of this medication to him/her as requested by the parents, including any adverse effects to the medication.

Parent/Guardian Signature_____ Date_____

***Order form good for one school year including Summer School.**

FOR STAFF ONLY: SIGNING HERE INDICATES THAT THE MEDICATION REVIEW HAS BEEN COMPLETED.

_____	_____	_____
SHA Signature & Date	Name of PHN Contacted By Phone & Date	PHN Signature & Date