

Antelope Valley Union High School District Seizure History and Medication Orders

***** PHYSICIAN SECTION *****		
The Authorized Health Care Provider (signing below) must be licensed within the State of California to prescribe medication. (California Education Code 49423 and 49423.6)		
Student Name	DOB	Date Authorized
Parent / Guardian Name		Work / Cell Phone
Parent / Guardian Name		Work / Cell Phone
Medication Name	Dosage	
Times a.m. p.m.	Route / Method Liquid Tablet Rectal	
This student has been diagnosed with _____ seizures.		
Rectal Diastat medication is required to be given after _____ minutes.		
If this medication is required during school hours, these orders will be in effect until July 31 st of the summer following the school year for which they are prescribed.		
Name of Authorized Health Care Provider		Signature
Address		Phone
***** PARENT SECTION *****		
Initials required # 1, 2 and 3 a or b		
no	yes	My child has more than one seizure type.
no	yes	My child has staring spells or absence seizures.
no	yes	My child has seizures involving one part of the body or partial seizures.
no	yes	My child has seizures involving the entire body.
no	yes	My child has seizures causing a loss of consciousness.
<p>1. I give my permission as the parent or legal guardian of the above named student to initiate this request for medication administration for my child. I acknowledge that my child may be assisted to administer this medication by a school employee trained by the District Nurse. Medications that do not have matching information on the written statement and the medication container, or are not in their original containers, will not be accepted or administered. Medication will be counted upon receipt in the health office. _____ initials</p>		
<p>2. In order for this medication to be available to my child at school, I give my permission for the credentialed school nurse to communicate directly with the student's physician, as may be necessary, regarding the physician's written statement or any other questions that may arise with regard to the medication. I may terminate my consent for administration of this medication at school at any time. _____ initials</p>		
<p>3a. My child has been trained to carry and self-administer this medication and is both responsible and capable of taking this medication, without assistance or supervision, at school. He / She is also capable and responsible to transport this medication to and from school. I release the district and school personnel from civil liability if my child suffers from an adverse reaction as a result of self-administering this medication. _____ initials</p>		
<p>or 3b. I request that my child be assisted and supervised during administration of this medication at school and not be permitted to administer or carry this medication without proper supervision from school personnel. _____ initials</p>		
Signature of Parent / Legal Guardian		Date