PARSIPPANY TROY-HILLS TOWNSHIP SCHOOLS

REQUEST FOR ADMINISTRATION OF MEDICATION

My child _____, date of birth _____, is in need of _____ medication during school hours/school sponsored events. I am requesting that the above medication be administered to my child as described in the written Health Care Provider's order, and according to Parsippany Troy-Hills district policy.

This request is effective for the _____ school year only.

_____ _____
Principal's Signature Date

_____ _____
Nurse's Signature Date

_____ _____
Parent's Signature Date

EPILEPSY FOUNDATION® Not another moment lost to seizures® epilepsy therapy project

STRONGER TOGETHER

Seizure Action Plan

Effective Date

This student is being treated for a seizure disorder. The information below should assist you if a seizure occurs during school hours.

Student's Name | Date of Birth

Parent/Guardian | Phone | Cell

Other Emergency Contact | Phone | Cell

Treating Physician | Phone

Significant Medical History

Seizure Information

Seizure Type	Length	Frequency	Description

Seizure triggers or warning signs:

Student's response after a seizure:

Basic First Aid: Care & Comfort

Please describe basic first aid procedures:

Does student need to leave the classroom after a seizure? ❒ Yes ❒ No

If YES, describe process for returning student to classroom:

Basic Seizure First Aid

- Stay calm & track time
- Keep child safe
- Do not restrain
- Do not put anything in mouth
- Stay with child until fully conscious
- Record seizure in log

For tonic-clonic seizure:

- Protect head
- Keep airway open/watch breathing
- Turn child on side

Emergency Response

A "seizure emergency" for this student is defined as:

Seizure Emergency Protocol
(Check all that apply and clarify below)

- ❒ Contact school nurse at _____
- ❒ Call 911 for transport to _____
- ❒ Notify parent or emergency contact
- ❒ Administer emergency medications as indicated below
- ❒ Notify doctor
- ❒ Other _____

A seizure is generally considered an emergency when:

- Convulsive (tonic-clonic) seizure lasts longer than 5 minutes
- Student has repeated seizures without regaining consciousness
- Student is injured or has diabetes
- Student has a first-time seizure
- Student has breathing difficulties
- Student has a seizure in water

Treatment Protocol During School Hours (include daily and emergency medications)

Emerg. Med. ✓	Medication	Dosage & Time of Day Given	Common Side Effects & Special Instructions

Does student have a **Vagus Nerve Stimulator?** ❒ Yes ❒ No If YES, describe magnet use:

Special Considerations and Precautions (regarding school activities, sports, trips, etc.)

Describe any special considerations or precautions:

Physician Signature _____ **Date** _____

Parent/Guardian Signature _____ **Date** _____

PARSIPPANY-TROY HILLS TOWNSHIP SCHOOLS

HEALTH SERVICES

MEDICATION AUTHORIZATION

Date_____

Dear Parent/Guardian:

You have indicated that (Name)_____

(Grade)_____ is in need of medication during school hours.

It is our policy to have written permission. Please have your physician complete and return to the school nurse.

1. Pupil's name _____
2. Diagnosis _____
3. Name of medication _____

   PLEASE NOTE: An order for epinephrine may be administered by a non-medical trained delegate who is authorized to administer epinephrine ONLY. As such, antihistamines or other medications cannot be given by the delegate. Please take this into consideration when writing your order. If you have any questions in this regard, please call the school nurse listed below. Thank you.
4. Dosage of medication _____
5. Route _____
6. Time to be given _____
7. Special instructions _____
8. Side effects _____
9. Signature of physician _____
10. Physician (Please print, type or stamp) _____

    _____

    _____

    _____

    Fax No. Date

Please submit this information as soon as possible, so that the proper schedule can be maintained. If there is any change during the course of this prescribed medication, please notify the school nurse in writing.

Very truly yours,

_____ _____

School Nurse Parent's Signature

School _____ _____

Date

Phone No. _____

SN# 3
3/16