Edmonds SCHOOL DISTRICT
Each student learning, every day!

Licensed Health Care Provider (LHCP) Authorization
For Administration of Emergency Anti-convulsant at School

HS 506

Student's Name _____ **Birthdate** _____

School _____ **Grade** _____

1. Has this student ever received an Emergency anticonvulsant? ☐ Yes ☐ No Last date given:_____

Name of emergency medication: _____

Type of seizures: _____

2. Administration of emergency anticonvulsant:

Medication: ☐ Diastat ☐ Midazolam ☐ Other: _____

Route: ☐ rectal ☐ nasal ☐ oral

Administer_____ mg of medication after seizure of _____ minutes duration or _____.

SIDE EFFECT: respiratory depression, sleepiness

Diagnosis	Medication	Dosage	Route	Time/Interval between doses	Self-Carry*	Side Effects
					Y N	
					Y N	
					Y N	

I request and authorize that the above-named student receive the above identified medications in accordance with the instructions indicated beginning ____/____/____ not to exceed current school year or ____/____/____.

LHCP's Signature: _____ Date: _____

LHCP's Name: _____ Phone Number: (_____) _____

LHCP's Address: _____ Fax Number: (_____) _____

SECTION CAN ONLY BE COMPLETED BY A HEALTH CARE PROVIDER WITH PRESCRIPTIVE AUTHORITY

Parent/Guardian Permission

The medication is to be furnished by me in the original container, labeled by the pharmacy with the name of the medicine, amount to be taken, and the time of day to be taken. The Licensed Health Care Provider's name is on the label. If medication remains after the course of treatment, I will collect the medication from the school or understand that it will be destroyed.

Signature of Parent/Guardian: _____ Date: _____

Student Signature (Self-Carrying):_____ Date: _____

Nurse Signature: _____ Date: _____

PLEASE TURN OVER TO COMPLETE OTHER SIDE

EDMONDS SCHOOL DISTRICT NO. 15
LYNNWOOD, WA 98036-7400
Educational Health Services

Administration of Medication in School

Medication should be given at school only when necessary. If the student must receive prescribed or non-prescribed oral or topical medication, eye drops, ear drops, or pre-mixed nasal spray medications during school hours or when the student is under the supervision of school officials, the principal and the school nurse will designate and train staff for dispensing medications. The medication to be given at school must have a written order signed by a Licensed Health Care Provider (LHCP) working within the scope of their prescriptive authority and have a parent/guardian signature. The medication must be in the original, properly labeled container. This includes any over the counter medication. Edmonds School District #15 accepts no responsibility for adverse reactions when the medication is dispensed in accordance with the LHCP order. Whenever possible the parent/guardian and LHCP are urged to design a schedule for giving medication outside of school hours. Students in K-6 grades are not recommended to self-carry.

THIS PORTION TO BE COMPLETED BY PARENT/GUARDIAN

I the Parent/Guardian Understands:

- When notified by school personnel that medication remains after the course of treatment I will collect the medication from the school or understand that it will be destroyed.
- Edmonds School District #15 assumes no responsibility for self-carried medications.
- In the event a safety issue arises, the school nurse has the right to notify the parent/guardian/student and discontinue the self-medication privilege. Student's health plan will be modified to reflect current needs.
- I will provide the medication in a properly labeled container.
- This authorization is only good for one school year.

Optional: ☐ **By checking this box I hereby give consent to have non-controlled medication returned home with student.**

My signature below indicates that I have read and understand and will abide by the medication policy.

Signature of Parent/Guardian: _____ Date: _____

Student Signature (Self-Carrying):_____ Date: _____