HEALTH SERVICES
Prosper Independent School District

Seizure Management: Parent Acknowledgement & Consent Form

*This form is to be renewed each school year, and as changes occur.

Student: _____ DOB: _____/_____/_____ Grade: _____

I, the undersigned parent/guardian of Student listed above, request that the Seizure Management and Treatment Plan ("Plan") completed by my healthcare provider on the form required by the Texas Education Agency and submitted to the school nurse, be implemented for my Student. Delivery of this Plan to the school nurse constitutes my participation in developing this Plan.

I understand that Prosper ISD protocol is for staff to call EMS for seizure activity lasting longer than 5 minutes, though my provider may have indicated *additional* times that EMS should be contacted related to my Student's seizure activity.

I understand that Prosper ISD will contact EMS and the parent/guardian when diazepam or midazolam is administered. After the administration of either of these medications, the Student will be required to go home to allow for the recovery from the medication and post-seizure effects. Based on EMS protocols, EMS may decide or recommend that the Student should be transported to the hospital for further treatment or monitoring.

In the event that I am unavailable or unable to pick up my Student after diazepam or midazolam has been administered, or for a prolonged postictal period (per Student's Plan), my child may be released to the following contacts:

1. _____ Relation to child: _____ Phone: _____
2. _____ Relation to child: _____ Phone: _____

For school nurse preparedness planning with school staff, does this Student ride the bus to/from school: ☐ Yes ☐ No
Does this Student participate in sports or other school sponsored extracurricular activities? ☐ Yes ☐ No
If Yes, please describe: _____

The emergency medications listed below must be available for administration during school hours. My signature below indicates that I request that Prosper ISD staff administer this medication to my Student. I agree to pick up any unused, discontinued, or expired medication upon notification by staff. I understand that medications not picked up will be disposed of at the end or the school year or within two weeks after the medication expires or is discontinued, whichever is earlier.

Emergency Medication: _____ **Expiration Date of the Med** (MM/YY): _____

Amount to be given:_____ **Route**: ☐ Intranasal ☐ Rectal ☐ By mouth

When to be administered: _____

Emergency Medication: _____ **Expiration Date of the Med** (MM/YY): _____

Amount to be given:_____ **Route**: ☐ Intranasal ☐ Rectal ☐ By mouth

When to be administered: _____

I understand that it is my responsibility to provide the necessary medications, equipment, and supplies in order for the Plan to be implemented at school by district personnel. I understand that the school administration will appoint a qualified designated person to perform the actions of the Plan. It is my understanding that in performance of the service, the designated person(s) will be using a standardized procedure that has been approved by the physician. I will notify the school immediately if the health status of my child changes, I change physicians, or the Plan is canceled or changed in any way. I also give my permission for Prosper ISD Health Services staff to contact the prescribing provider and pharmacy for additional information or clarification regarding my Student's Plan or the prescribed medications noted within, as needed.

Parent/Guardian Name: _____ Relationship to Student: _____ Phone: _____

Parent/Guardian Signature: _____ Date: _____

INTERNAL USE ONLY----------

Med #1: RN Initial Review:_____ ☐ Skyward MAR RN Reviews: _____ / _____ / _____ / _____

Med #2: RN Initial Review:_____ ☐ Skyward MAR RN Reviews: _____ / _____ / _____ / _____