CONFIDENTIAL

AUTHORIZATION FOR SPECIALIZED CARE

MOLALLA RIVER

AUTHORIZATION FOR SEIZURE ACTION PLAN

Student Name:		DOB	

As the parent of the above identified student, I request that my child receive the following health services as per written nursing protocol, nursing care plan and/or MD orders as it relates to my student's chronic diagnosis and specialized care of:

Diagnosis

☐ Seizure Disorder
- ☐ Absence Seizures
- ☐ Partial Complex Seizures
- ☐ Generalized Seizures

Procedure

☐ Standard Seizure Procedure
☐ Response to seizures:
- ☐ Rectal Diastat
- ☐ Intranasal versed
- ☐ Buccal Midazolam
- ☐ Sublingual ☐ Lorazepam ☐ Clonazepam
- ☐ Other:_____

_____
_____

Associated Prescription: ☐ N/A

Right Student	
Right Medication	
Right Dose	
Right Time	
Right Route	

I understand that:

- This authorization is valid for one year from the date of my signature below.
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- Qualified, designated persons will be performing the above-mentioned health care service(s) and the designated persons will be trained and supervised by a registered nurse as authorized by OAR 851-047-0000.
- I will notify the school immediately if the health status changes, if there is a change of physicians, changes to physician's orders, and/or change or cancellation of health care.
- I am responsible for bringing to school all necessary supplies or medications to school.

Parents Signature Date