

Aug 13 2017 12:10 PM Florida Epilepsy Center 4077467999

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ENCL. LHM/ESTATES

PAGE 03



Seminole County Public Schools Health Service

Seizure Medical Management Plan

School Year 2017 - 2018

TO BE COMPLETED BY PARENT

Student Name	[REDACTED]	Date of Birth	[REDACTED]
School	English Estates	Grade	
Allergies			
CONTACT INFORMATION			
Parent/Guardian	[REDACTED]	Phone	407-283-25
Parent/Guardian		Phone	

The following section is to be completed by the prescribing licensed healthcare provider. Please be aware that this medication may be administered by trained unlicensed school personnel.

FOR LICENSED HEALTH CARE PROVIDER USE ONLY

Describe the type and duration of seizure that requires the administration of the medication listed below.

Type GTIC or focal seizure Duration > 3 minutes

Medication Nidazole Strength 10mg/ml Dose 0.3ml Route nasal
per nostril

Additional administration instructions May repeat 1 time if seizure doesn't stop after 5 mins.

List any significant side effects to this medication drowsiness, headache, nausea

Oxygen N/A

Other considerations Do not restrict patient during seizure, keep at an air side

Licensed Health Care Provider Signature _____ Date 08/11/2017

Printed Name Joe Hoo See, MD Phone 407-303-8127

Address 615 E. Princeton St. 540, Orlando FL 32803 Fax 407-303-8197

The following section is to be completed by the parent/guardian.

- I hereby grant permission to Seminole County Public Schools and its designees to assist in the administration of the above-prescribed medication to my child while in school and during school sponsored activities (FS 1008.222).
- I give permission for my child's doctor to be contacted if needed, regarding administration of the above medication.
- It is my responsibility to provide a new medication authorization form if and when these orders change.
- Medication must be in the container in which it was purchased. Prescription medications must have a pharmacy label attached that contains this authorization.
- I understand that if emergency medication is administered I will be called to evaluate my child. I further understand that if this determines my child does not need to be transported to the hospital, it is my responsibility to arrange for my child to be picked up from school immediately (within 30 minutes) for follow-up monitoring.

Parent/Legal Guardian Signature _____ Date _____

Parent/Legal Guardian Printed Name _____

School Board Name Signature _____ Date _____

THIS AUTHORIZATION IS VALID FOR THE CURRENT SCHOOL YEAR ONLY, INCLUDING SUMMER SCHOOL.

Rev. 08/07

Todd M. Husty 11-16-17
Medical Director SCPS

09/21/2017 07:57

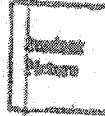
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(FAX)

P.002/002



SEMINOLE COUNTY PUBLIC SCHOOLS STUDENT MEDICATION AUTHORIZATION



Student Name: [REDACTED] Sex: M DOB: [REDACTED] School Year: 17-18
 School: Winter Springs Grade: PK Phone: [REDACTED] Fax: [REDACTED]
 Email: [REDACTED]

The following section is to be completed by the prescribing licensed healthcare provider prior to administering medication. Please be aware that this medication may be administered by trained certified school personnel.

MEDICATION INFORMATION

FOR LICENSED HEALTHCARE PROVIDER USE ONLY:

Condition for which medication is being administered: Adrenal Insufficiency
 Name of medication(s): Solu-Cortef

Route to administer (please check one): ☐ Oral ☐ Inhaled ☒ Injected ☐ Topical ☐ Other (describe)

Dosage: 50mg IM Frequency: Once PRN Unresponsive, Seizure

If to be given as needed, for what symptoms? Unresponsive, Seizure

List any significant side effects to medication:

FOR SELF CARRY/SELF ADMINISTRATION OF EMERGENCY MEDICATION AND PANCREATIC ENZYMES:

In accordance with FS 1002.30, I authorize this student to carry and self-administer the inhaler, syringe/insulin auto-injector or pancreatic enzymes as described above and have instructed the student on its use. ☐ Yes ☒ No

FOR HIGH SCHOOL STUDENTS ONLY:

Is this high school student authorized to carry and self-administer this medication? ☐ Yes ☒ No N/A

THIS AUTHORIZATION IS VALID FOR THE CURRENT SCHOOL YEAR ONLY, UNLESS OTHERWISE NOTED.

Signature of Parent/Guardian: [Signature] Date: 9/20/17

Printed Name: Jennifer Vilal Phone Number: 321-841-3303

Address: 60 W Grove St. Orlando, FL 32806 Fax Number: 321-841-3305

I am submitting this form in the presence of a responsible adult.

[Signature]
 Todd M. Hasty, Medical Director SCFD

11-16-17

08/07/2017 12:03 407-746-3810

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02807 P. 002/002

**SEMPER PARVUS COUNTY PUBLIC SCHOOLS
STUDENT MEDICATION AUTHORIZATION**

Student
Parent

Student Name: [Redacted] M. [Redacted]
 School: [Redacted] School Grade: 10
 The following medication is to be administered to the student at the school during the school day. It is to be administered by the school nurse or designated personnel.

STUDENT INFORMATION

Medication Name: Penhyposit

Medication Type: Solo-Cort's Morning Injection

Amount: 50mg ☐ Oral ☐ Inhaled ☐ Topical ☐ Other (Specify):

Frequency: As needed ☐ Daily ☐ Weekly ☐ Monthly

Indication: In case of severe illness such as fever
More than 102°F or Severe fatigue
Exhaustion, mental status change

FOR SELF-ADMINISTRATION OF MEDICATION AND FOR THE NURSE:

I, the undersigned, authorize the school nurse to administer the medication as indicated above and have instructed the student on how to use the medication.

FOR NURSE/STUDENT USE ONLY:

In the event the student is unable to use the medication as indicated above, the school nurse will administer the medication as indicated above.

THIS AUTHORIZATION IS VALID FOR THE CURRENT SCHOOL YEAR ONLY, EXPIRING AUGUST 31, 2018.

Signature: Yvonne V. [Redacted] Date: 11/16/17

Address: 3300 E. Lake Mary Blvd Ste 100 Phone: 407-650-7210
Lake Mary, FL 32746

- The following criteria are to be completed by a parent/guardian:
- I hereby grant permission to the school nurse to administer the medication to my child at the school during the school day.
 - I give permission for the school nurse to administer the medication to my child at the school during the school day.
 - It is my responsibility to provide the school nurse with a copy of this authorization and to inform the school nurse of any changes to the medication.
 - I understand that the school nurse will not be responsible for the medication if it is not administered as indicated above.

Parent/Guardian Signature: [Redacted] Date: [Redacted]
 Parent/Guardian Printed Name: [Redacted]
 School Nurse: [Redacted] Other: [Redacted]

02807 Form 1.000 02/01/14

Printed Name of the person who signed the document for parent/guardian

Todd M. Hasty Medical Director