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
☐ Seizure response with:
- ☐ Vagus Nerve Stimulator
- ☐ Medication
  - ☐ 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.
- 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