Muskogee Public Schools
Parental Authorization to Administer Seizure Rescue Medication

TO: ___________________________________________ (Administrator) ___________________________________________ (School)

I am the parent, guardian or legal custodian with legal custody of ________________________________, a minor student attending this school.

During the school day, this student may require administration of a seizure rescue medication by authorized School District personnel. I hereby give my consent and authorize the school nurse, the principal, or ________________________________ (an employee of the School District designated by the school nurse, the principal, and me) for the ____________________________ school year to administer ________________________________ (name of drug), a seizure rescue medication which I am hereby supplying you in its unopened, sealed package with the label affixed by the dispensing pharmacy intact.

I understand that under state law before a seizure rescue medication can be administered to the student at school, I must do the following:

1. provide the school with this written authorization to administer seizure rescue medication at school;
2. provide the school with a written statement from my child’s health care provider that must contain the following information:
   a. the student’s name,
   b. the name and purpose of the medication,
   c. the prescribed dosage,
   d. the route of administration,
   e. the frequency that the medication may be administered, and
   f. the circumstances under which the medication may be administered;
3. provide the prescribed medication to the school in its unopened, sealed package with the label affixed by the dispensing pharmacy intact; and
4. collaborate with school personnel to create a seizure action plan.

I understand that under state law employees of the School District shall not be liable to the student or the student’s parent or guardian for civil damages for any personal injuries to the student which result from acts or omissions of school employees taken in compliance with the Seizure-Safe Schools Act unless that employee’s actions rise to a level of reckless or intentional misconduct. I also understand that under state law, a school nurse shall not be responsible for actions performed by a volunteer.

I agree to abide by all of the terms of the School District’s Policy on the Administration of Medicine to Students, a copy of which will be given to me on my request. I also understand my obligations under this policy must be fulfilled before the school can administer a seizure rescue medication to my child and that this written authorization is only valid for the current school year and must be renewed every succeeding school year before seizure rescue medication can be administered to my child at school for that school year.

__________________________________________ Date

__________________________________________ Signature
| Address | Parent with legal custody/guardian |
Muskogee Public Schools
Statement of Health Care Provider Regarding Administration of
Seizure Rescue Medication at School

To whom it may concern:

Pursuant to the Seizure-Safe Schools Act, OKLA. STAT. tit. 70, §1210.183 (2021), before School District personnel may administer a seizure rescue medication to ____________________________________________________________________________, birthdate __________ (“student”), the following information must be provided to the School District by the student’s physician.

Please print legibly or type the following information:

1. Student’s Name ___________________________________________________________________;

2. Name and Purpose of the Medication ________________________________________________________________________________________;

3. Prescribed Dosage ___________________________________________________________________________________________________________

4. Route of Administration _______________________________________________________________________________________________________

5. Frequency by which Medication may be Administered ___________________________________________________________________________; and

6. Circumstances under which Medication may be Administered __________________________________________________________________________;

________________________________________________________________________________

________________________________________________________________________________

I affirm that I am the student’s physician and that the information provided on this form is accurate and was provided by me.

Signature of Physician (or Adult Student) __________ Printed Name & License No. __________