

Seizure Medication Administration Record (SMAR)



Department of Health

Do not use for general medications.
This form does not replace standard individual healthcare plans.

STUDENT INFORMATION

Student Name:			Date of Birth:
Student Address:			Student Phone #(if applicable):
Parent/Guardian Name:			Parent/Guardian Phone #:
School:	Grade/Homeroom:	Teacher:	School Year:
List Any Known Drug Allergies/Interactions:		Height:	Weight:

PRESCRIBER AUTHORIZATION / TREATMENT PROTOCOL DURING SCHOOL

A) Daily / Routine In-School Medications:

Name of Medication:	Concentration / Formulation:	Dose:	Route:	Frequency or Time:	Side Effects / Specific Instructions:

Date to Begin Medication: _____ Date to End Medication: _____

Possible Severe Adverse Reaction(s):

a) To the student for whom it is prescribed (that should be reported to the prescriber):

b) To a student for whom it is not prescribed who receives a dose:

B) Does Student Have a Vagal Nerve Simulator (VNS)? (Any Trained Adult Can Administer)

No Yes, If YES Describe Magnet Use: _____ Swipe Magnet Immediately
 Within ___ min; if seizure continues, repeat after ___ min ___ times: give emergency medication after ___ min and call 911 / EMS.

C) Emergency Medication(s) (List in Order of Administration) [Nurse Must Administer]; Call 911 / EMS Immediately After Administration.

Name of Medication:	Concentration / Preparation:	Dose:	Route:	Administer After:	Side Effects / Specific Instructions:

Procedures for School Employees if it does not Produce the Expected Relief:

Special Medication Instructions Including Definitions of Terms Such as a Cluster (See Individualized Health Plan for Additional Information):

Does medication require refrigeration? Yes No

Yes, as the prescriber, I approve for this student to possess this drug prescribed to prevent the onset of a seizure or to alleviate the symptoms of a seizure if conditions under ORC 3313.7117 are satisfied. Not Applicable

Prescriber Signature:	Phone:	Fax:	Date:
Prescriber Name and Address:			



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PARENT / GUARDIAN AUTHORIZATION

I authorize an employee of the school board to administer the above medication(s). I understand that additional parent/prescriber signed statements will be necessary if the dosage of medication(s) is changed. I also authorize the licensed healthcare professional to talk with the prescriber or pharmacist to clarify medication order.

Medication form must be received by the principal, their designee, and/or the school nurse. I understand that the medication must be in the original container and be properly labeled with the student's name, prescriber's name, date of prescription, name of medication, dosage, strength, time interval, route of administration and the date of drug expiration when appropriate.

Parent Guardian Signature:	Date:	#1 Contact Phone:	#2 Contact Phone: