

I.T.M. WELLNESS CLINIC

Student Agreement to Carry Emergency Seizure Medication

Name: _____ Grade _____ DOB _____

Name of Medication _____

I agree to:

- Keep a supply** of my medication **with me** at school and on field trips
- Not allow anyone else to use my medication, under any circumstances**
- Notify** the teacher, nurse, principal, office clerk, or anyone with me **if I feel like I am about to have a seizure**, I will **NOT leave the classroom alone**, climb stairs, cross traffic lanes, carry hot beverages or operate equipment/ machinery **if I Feel like I am about to have a seizure.**

I UNDERSTAND THAT MY PERMISSION TO CARRY MY MEDICATION MAY BE DISCONTINUED IF I AM UNABLE TO FOLLOW THE GUIDELINES ESTABLISHED ABOVE.

Signature of Student

Date

Verbalized signs and symptoms of Impending Seizure Activity

Feeling excessively sleepy

Dizziness

Feeling Tired

Headache

Fast heart beat

Other _____

The student has/has not demonstrated/Verbalized adequate knowledge to assume responsibility of carrying medication.

Signature of Nurse

Date