Lynn Public Schools
School Health Services
Anti-Convulsant Medication Order Form

To be completed by a Licensed Prescriber: Physician, Nurse Practitioner or others authorized by Chapter 94c

Name of Student_____ Date of Birth _____

Address _____ Grade _____

Name of Licensed Prescriber _____ Title_____

Business Telephone _____Emergency Telephone _____

Diagnosis* _____

Allergies* _____

Date of last seizure* _____

Any other medical conditions*_____

Date of Order _____Discontinuation Date_____

Name of Medication _____ Dosage _____ Route _____

Give for seizure lasting greater > than _____minutes then ACTIVATE 911.

If the school nurse is not available including field trips, school staff trained in seizure precautions will activate 911. **YES** □ **NO** □

If a student has a seizure during bus transportation, 911 will be activated. **YES** □ **NO** □

Other specific directions or information for medication administration: _____

_____

_____

Optional Information

Special side effects, contraindications, or possible adverse reactions to be observed:

_____

Other medication taken by the student:

_____

The date of the next scheduled visit or when advised to return to the Prescriber

_____

Signature of Licensed Prescriber _____

*If not in violation of confidentiality

DLT 6/2022