Student: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade: \_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_

Teacher(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ School Year \_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| **Responsibilities and Agreements** | | |
| **School** | **Family** | **Student** |
| Medication and supplies kept:  Clinic  Main Office  Classroom  Student Book Bag  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Provides medication and supplies for school site.  Pick-up and replace any expired medication  Med Name/Exp Date:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Med Name/Exp Date:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Report any early signs and symptoms of seizure onset |
| UAP to administer medication(s) per MDCPS trainings (i.e., review action plan, recognize symptoms, and respond):  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Keep school staff informed of any changes in student condition, medication(s), and updated emergency contact information  Any change in the medication regimen requires new medication authorization forms. | Wear a medical identification tag or jewelry |
| Administration to contact 911/parent/guardian in case of an emergency | Parent or designated adult, as noted on the emergency contact card, to respond to school when called |  |
| Administration and/or security to direct EMS to the emergency |  |  |
| CPR Certified Staff:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
| Security/Teacher to carry school two-way radio and/or have emergency intercom access |  |  |
| Follow Emergency Action Plan. If no plan is submitted, call 911 and parent/guardian |  |  |
| Ensure all MDCPS staff that regularly interact with the student receive seizure training, as per House Bill 173 |  |  |
| Assign staff to administer medication on field trips, if applicable |  |  |

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Parent/Guardian Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Principal/School Administration Designee Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

School Nurse Date