

SUMNER COUNTY SCHOOLS  
SEIZURE IHP/SAFETY PLAN-PRESCRIPTION  
MEDICATION ORDERS

Student Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Address: \_\_\_\_\_ Age: \_\_\_\_\_ Grade: \_\_\_\_\_ Teacher: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Phone: \_\_\_\_\_

Emergency Contact/Relationship \_\_\_\_\_ Phone: \_\_\_\_\_

Neurologist/Provider: \_\_\_\_\_

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Medical Provider Portion

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Rescue Medication Instructions

If seizure (cluster, # or length) \_\_\_\_\_

Name of Med/RX \_\_\_\_\_ How much to give (dose) \_\_\_\_\_

How/When to give \_\_\_\_\_

Care After Seizure

What type of help is needed?(describe) \_\_\_\_\_

When is student able to resume usual activity? \_\_\_\_\_

Daily Medication

Medicine Name	Total Daily Amount	Amount of Tab/Liquid	How Taken (time of each dose and how much)

entus 100mg (en-US) 20-01-01-01