AUTHORIZATION TO GIVE MEDICATION: Diastat

Medications will be given at school only with written permission from the child's parent(s) or legal guardian. Emergency medications must have written permission from the Health Care Provider to administer. In the event of a seizure emergency, the following procedure should be followed by a school nurse or designated trained personnel. Signed permission will expire at the end of school year.

Student's Name_____ Date of Birth_____

Seizure information:

Type of Seizure(s)	**Description**
☐ Absence	*Staring, eye blinking, loss of awareness, other_____
☐ Complex Partial Seizures	*Remains conscious, distorted sense of smell, hearing, sight, involuntary rhythmic jerking/twitching on one side, other_____
☐ Generalized tonic-clonic seizures	* Convulsions, stiffening, breathing may be shallow, lips or skin may have bluish color, unconsciousness, confusion, weariness, or belligerence when seizure ends, other _____

If a seizure occurs, activate the following EMERGENCY PLAN OF ACTION:

EMERGENCY PLAN OF ACTION

1. Administer emergency medication DIASTAT (diazepam rectal gel)
   ____mg rectally for seizure lasting longer than _____ minutes and or > _____seizures in _____hours.
   Possible side effects:_____
   - VNS (Vagal Nerve Stimulator) Magnet
   - Other_____
2. Call EMS (911) if:
   - **Diastat is given**
   - Seizure does not stop by itself or with VNS within _____ minutes.
   - Seizure lasts more than 5 minutes.
   - Child does not start waking up within _____minutes after seizure is over.
   - Seizure behavior is different from other episodes.
   - You are alarmed by the frequency or severity of the seizure(s).
   - You are alarmed by the color or breathing of the person.
   - The person is having unusual or serious problems.
3. Notify school personnel trained in CPR/First aid to stay with student and initiate CPR if needed prior to EMS arrival.
4. Notify parent/guardian.
5. If child needs to be transported via EMS, a parent or school representative will meet student at the hospital.

Diastat should be _____kept with child _____kept in front office_____ __available during transportation.

Signature of MD, ARNP, or PA_____Date:_____

Primary Care Provider_____ Phone #_____

I give permission for myself/my child to receive the above medication at school according to school policy and expressly waive any liability on behalf of the school as a result of administration of the above medication. I understand that I have the ultimate responsibility for providing the school with an adequate supply of medication to enable the request for medication to be followed. My signature will give permission for exchange of verbal and written communication between the Health Care provider and the school nurse regarding my child's medical regime. I hereby give my authorization and consent to trained school personnel to give prompt treatment, as specified above under Emergency Plan of Action, to my child.

Signature of Parent/Guardian_____Date_____

Home Phone_____ Work Phone_____

Emergency Contact_____ Phone #_____