Medical Authorization for Management of Seizures at School - DIASTAT

Student: _____ Birth Date: _____ Grade: _____

THIS PORTION TO BE COMPLETED BY THE PARENT/GUARDIAN

Parent Section ***Seccion De Padres***	**I, the undersigned parent/guardian of the named student, request that all procedures and administration of medication be performed as authorized by the Health Care Provider in accordance with state laws and regulations. I understand and agree to:** *Yo, el padre o tutor legal del alumno nombrado en este documento, pido que todo procedimiento médico o administración de medicamento se realice de forma autorizada por el médico de acuerdo con las reglas y las leyes estatales. Entiendo y estoy de acuerdo con lo siguiente:* 1. **Notify the school nurse if the medication was administered to my child within 12 hours of attending school.***Avisaré a la enfermera escolar si es que mi hijo tomó medicamento a menos de 12 horas de haber asistido a la escuela.* 2. **Notify the school nurse of any changes in my child's seizure activity.** *Avisaré a la enfermera escolar de cualquier cambio en convulsiones.* 3. **Maintain current phone numbers with the school.** *Mantendré actualizados mis números telefónicos con la escuela.* 4. **Provide the necessary medication, supplies, and equipment.***Traeré el medicamento, suministro y equipo necesario.* 5. **911 will be called whenever this medication is used.***Se llamará al 911 cuando se use este medicamento.* **I authorize the school nurse to communicate with the Health Care Provider on matters related to my child's seizure disorder, medication, and school treatment plan. I understand that expired medications will be properly disposed of by the school nurse unless otherwise requested.** *Yo autorizo a la enfermera escolar que se comunique con el médico de mi hijo en cuanto a convulsiones, medicamento y el plan de tratamiento escolar. También entiendo que los medicamentos expirados estarán adecuadamente desechados por la enfermera de la escuela, a menos que los solicite.* _____ _____/_____ Signature/*Firma* Date/*Fecha* Phone #1/Phone #2

THIS PORTION TO BE COMPLETED BY THE HEALTH CARE PROVIDER

Diagnosis or condition for which medication is prescribed:
Method of administration: Pre-filled rectal syringe(s) to be administered only by the following if available: *Licensed school nurse, Paramedic responding to 911 call, or the parent*
Name of medication: DIASTAT **Dosage:**_____
To be given AS NEEDED. <u>Medical Provider to specify indications for usage:</u>
Other Instructions:
Possible side effects of medication: Sedation, Respiratory Depression
Emergency procedure: Call 911, follow the student's care plan, call the parent/guardian
This authorization is valid: ☐ For the current school year; or ☐ From _____ to _____
I authorize that the above named student be administered this medication at school as directed. _____ _____ Health Care Provider Signature Health Care Provider Print _____ _____ _____ Health Care Provider phone # Health Care Provider phone # Date

March 2018

Medical Authorization for Management of Seizures at School - MIDAZOLAM

Student: _____ Birth Date: _____ Grade: _____

THIS PORTION TO BE COMPLETED BY THE PARENT/GUARDIAN

Parent Section

Seccion De Padres

I, the undersigned parent/guardian of the named student, request that all procedures and administration of medication be performed as authorized by the Health Care Provider in accordance with state laws and regulations. I understand and agree to:
Yo, el padre o tutor legal del alumno nombrado en este documento, pido que todo procedimiento médico o administración de medicamento se realice de forma autorizada por el médico de acuerdo con las reglas y las leyes estatales. Entiendo y estoy de acuerdo con lo siguiente:

1. **Notify the school nurse if the medication was administered to my child within 12 hours of attending school.** *Avisaré a la enfermera escolar si es que mi hijo tomó medicamento a menos de 12 horas de haber asistido a la escuela.*
2. **Notify the school nurse of any changes in my child's seizure activity.** *Avisaré a la enfermera escolar de cualquier cambio en convulsiones.*
3. **Maintain current phone numbers with the school**. *Mantendré actualizados mis números telefónicos con la escuela.*
4. **Provide the necessary medication, supplies, and equipment.** *Traeré el medicamento, suministro y equipo necesario.*
5. **911 will be called whenever this medication is used**. *Se llamará al 911 cuando se use este medicamento.*

I authorize the school nurse to communicate with the Health Care Provider on matters related to my child's seizure disorder, medication, and school treatment plan. I understand that expired medications will be properly disposed of by the school nurse unless otherwise requested. *Yo autorizo a la enfermera escolar que se comunique con el médico de mi hijo en cuanto a convulsiones, medicamento y el plan de tratamiento escolar. También entiendo que los medicamentos expirados estarán adecuadamente desechados por la enfermera de la escuela, a menos que los solicite.*

_____ _____/_____
Signature/*Firma* Date/*Fecha* Phone #1/Phone #2

THIS PORTION TO BE COMPLETED BY THE HEALTH CARE PROVIDER

Diagnosis or condition for which medication is prescribed:

Name of medication: MIDAZOLAM

Dosage: ☐ 1ml vial (5mg/1ml) ☐ 2 ml vial (10mg/2ml)

Method of administration: Give _____ mg or _____ ml intranasally.
Give one-half dose in each nostril.

To be given AS NEEDED. <u>Medical Provider to specify indications for usage:</u>

Other Instructions:

Possible side effects of medication: Sedation, Respiratory Depression, Unsteadiness, Behavior Changes

Emergency procedure: Call 911, follow the student's care plan, call the parent/guardian

This authorization is valid: ☐ For the current school year; or ☐ From _____ to _____

I authorize that the above named student be administered this medication at school as directed.

_____ _____
Health Care Provider Signature Health Care Provider Print

_____ _____ _____
Health Care Provider phone # Health Care Provider phone # Date