NELSON COUNTY SCHOOLS

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 the written permission from the physician 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 the 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 > _____ minutes and/or > _____ seizure in ____ hours
   Possible side effects: _____
   ☐ VNS (vagal nerve stimulator) Magnet
   ☐ Other _____
2. Call EMS (911) if:
   - Seizure does not stop within _____ minutes of giving DIASTAT
   - Seizure lasts more than five (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.

I give permission for myself/my child to receive the above medication at school and waive any liability on behalf of the school. I understand that I have the ultimate responsibility for providing the school with an adequate supply of medication. My signature will give permission for exchange of verbal and written communication between the physician and the school nurse/health staff regarding my child's medical regime.

Signature of Parent or Legal Guardian _____ **Date** _____

Home phone _____ **Work phone** _____

Emergency contact name _____ **Phone number** _____