Request for Administration of Intranasal Midazolam (Versed)

Student's Name: ____Birthdate: __________________

- The student's Washington State licensed health care prescriber must complete and sign Section I of this form prior to the child starting school each year.
- Parent/guardian must complete and sign Section II of this form prior to the child starting school each year.
- This completed form must be on file in the student's health record before prescription medication will be administered by school personnel.
- **This medication will only be given by Licensed Nursing staff at school.**

I. Prescriber's Section

This is to certify that the student named above is under my care for a seizure disorder and may need to have emergency Intranasal Midazolam administered by licensed nursing staff. Please indicate when Intranasal Midazolam is to be administered:____

____

Name of drug: Midazolam ☐ 1 ml vial (5mg/1ml) ☐ 2 ml vial (10mg/2ml)

Total dosage to be administered: ☐ mg / ☐ ml

Nasally: ½ Right nostril ☐ ml ½ Left nostril ☐ ml

Adverse reactions that should be reported to the prescriber: ____

____

Storage instructions: ____

____

Other special instructions: ____

____

I understand that 911 will be called when Intranasal Midazolam is given.

Prescriber's signature/title: ___________________________________ Date: ______________________________

Prescriber (printed): ____Phone: _____________Fax:_______________

II. Parent/Guardian's Section

I hereby request and give my permission for school district licensed nursing staff to administer the prescribed Intranasal Midazolam to my child in accordance with the specific written instructions of our medical provider. I do hereby release all school employees and the Board of Education from liability for damages, illness, or injury resulting from either performing or not performing any assistance requested.

I am responsible for the delivery of the Intranasal Midazolam to the school and will notify the school immediately if the doctor changes the dosage or we change our medical provider or the need for Intranasal Midazolam is terminated.

I understand this medication can only be administered to my child by a licensed nurse.

911 will be called when Intranasal Midazolam is given.

Parent/Guardian signature: ___________________________ Date: __________________________

Home address: _____________________________________ Phone: _________________________

MEDICATION AT SCHOOL RULES

- Prescription medications must be in the original labeled container from the pharmacy.
- Over-the-counter medication must be in the original container.
- Any changes to this medication will require a new medication form completed by both parent and health care provider.
- Under normal circumstances prescribed **oral, nasal spray, topical, eye drop or ear drop** medication and over-the-counter **oral, nasal spray, topical, eye drop or ear drop** medication should be dispensed before and/or after school hours under supervision of the parent / guardian.
- Medications will only be dispensed at school when failure to receive the medication may result in the student being unable to attend school or to be well enough to participate in learning activities.
- If a student must receive prescribed or over-the-counter medication during school hours, the parent must submit a Medication at School form completed and signed by both the parent and a licensed heath care provider.
- Only the amount of medication needed during school hours for the course of the illness/condition is to be sent to school, not to exceed a one month's supply.
- Medications that must be given in half-pill doses must be cut by the pharmacy or the parent. The school will not cut pills.
- Parent or designated adult to bring medication to school (students should not transport medication to school).
- When the duration of a medication is complete or out of date, or at the end of the school year, the parent must pick up any unused portions of the medication. Unclaimed medications will be discarded.
- Bus drivers will not transport or administer medication.
- In case of necessity, the school district may discontinue administration of the medication with proper advance notice.

Authorization for Mutual Exchange of Confidential Information

Purpose: *As a parent, guardian or student, you have the right to give permission or not give permission for the release of your child's records with other persons or agencies. This request provides you with the opportunity to approve or not approve such a request unless release of records is allowed under one of the exceptions under the rules implementing the Family Education Right and Privacy Act. FERPA, (for example, transfer of records from one school district to another).*

Student Name: ____________________ Date: ____________ DOB: ____________

I hereby authorize the release of records

From:		***To:***	
Agency/Person:		**Agency/Person:** ***KSD Nurse***	
Street Address:		**Street Address:**	
City, State, Zip:		**City, State, Zip:** ***Kennewick, WA,***	
Tel:	***Fax:***	***Tel: 509-222-***	***Fax: 509-222-***

Describe records to be disclosed: *Diagnoses, medication, medical recommendations applicable for student at school.*

The reason for disclosing the record(s) is: *To provide safe care of the student in the educational setting*

This authorization is valid from: _____/_____/_______ *to:* _____/_____/_______.

I understand that this information obtained will be treated in a confidential manner by the school district under the provisions of the Family Education Rights and Privacy Act (FERPA). FERPA prohibits disclosure of personally identifiable information without consent except in limited circumstances. Please note that if the request is for health or medical information, the medical information received by the district is protected under FERPA privacy standards by a school district and not the Health Insurance Portability and Accountability Act (HIPAA).

I understand my consent for the release of records is voluntary and I can withdraw my consent at any time in writing. Should I withdraw my consent, it does not apply to information that has already been provided under the prior consent for release.

Parent/guardian/student signature:	Date: