WESTERN PLACER
UNIFIED SCHOOL DISTRICT
600 Sixth Street, Suite 400, Lincoln, CA 95648 Ph: 916-645-6350

PARENT NOTIFICATION REGARDING DIASTAT ADMINISTRATION AT SCHOOL

Date: _____

Dear Parent or Guardian of _____,

Per Education Code 49414.7, when requesting that a nonmedical district employee be trained to provide emergency medical assistance to his/her child, the parent must be notified that his/her child may qualify for services or accommodations pursuant to 20 USC 1400-1482, the Individuals with Disabilities Education Act (IDEA), or 29 USC 794, Section 504 of the federal Rehabilitation Act of 1973 (Section 504). This serves as your notification.

Also in accordance with Education Code 49414.7, be assured that:

- Any employee who volunteers to administer an emergency antiseizure medication receives training from a licensed health care professional before administering such medication. When a trained employee has not administered an emergency antiseizure medication to a student within two years after completing the training, he/she shall attend a new training program to retain the ability to administer an emergency antiseizure medication.

- Any training provided for district employees who volunteer to administer emergency antiseizure medications to students includes, but is not limited to:
  a. Recognition and treatment of different types of seizures
  b. Administration of an emergency antiseizure medication
  c. Basic emergency follow-up procedures, including, but not limited to, a requirement for the principal or designee to call the emergency 911 telephone number and to contact the student's parent/guardian, but not necessarily to transport the student to an emergency room
  d. Techniques and procedures to ensure student privacy

Please review and complete the attached forms with your child's healthcare provider and return them to the school site.

Parent/Guardian Signature: _____ Date: _____

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REQUEST FOR DIASTAT ADMINISTRATION AT SCHOOL

Dear Parent or Guardian:

Please complete the first page of this form yourself give the second page of this form to your student's physician authorizing Diastat in the school setting. Return both forms to the health office at your child's school.

The following section is to be completed by the PARENT/GUARDIAN:

Student Name: _____ Date of Birth: _____

School: _____ Grade: _____

List any known drug allergies/reactions: _____

Has your child received Diastat before? ☐ Yes ☐ No How many times? _____

Parent request: (Please initial indicating that you have read each statement. Place a checkmark in the boxes indicating the action(s) you wish to have taken regarding the administration of Diastat).

☐ _____ Initial

I request that the emergency anti-seizure medication, Diastat, be administered to the above student at school. I also give my permission for exchange of information between school district staff and the health care provider. I understand the medication is to be furnished by me, in the original container, labeled by the pharmacy with the name of the medication, prescriber name, student's name, and dose. I hereby release Western Placer Unified School District and all its employees from any and all liability for damages my child may suffer as a result of this request. I hereby give my consent for information to be released to school staff, host school staff, transportation staff and emergency personnel as needed to provide quality of care. This authorization is valid through July 31st of each school year and may be revoked at any time.

☐ _____ Initial

I request that in the absence of a school nurse or other licensed nurse, one or more school employees may volunteer to be trained to administer the emergency anti-seizure medication, Diastat, to my student during the regular school day. I understand that a nurse is not on the school site every day. In the event of a seizure, that may require medical attention, a nurse will be dispatched to the school site. In addition to contacting a nurse, 911 will be called. When available, the nurse or trained volunteer school personnel will administer Diastat.

- I understand that I am responsible for notifying the school if a student has been administered Diastat within 4 hours before a school day
- I understand that the manufacturer recommends that Diastat not be given for more than 1 episode in a 5 day period or 5 episodes in a 30 days period. I am therefore responsible for notifying the school if Diastat has been administered at home in these time frames when a dose given at school would exceed the manufacturer recommendations.

Parent/Guardian Signature: _____ Date: _____

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PHYSICIAN'S ORDERS FOR THE ADMINISTRATION OF DIASTAT AND SEIZURE CARE PLAN

(TO BE COMPLETED BY THE STUDENT'S PHYSICIAN)
School Year 20____ - 20____

Student Name: _____ Date of Birth: _____

Seizure Type: _____ Frequency: _____ Length: _____

Description of Seizures: _____

Seizure Triggers: _____

Please Complete the Following Diastat Orders for Treatment:

- DIASTAT AcuDial (diazepam rectal gel) _____mg, rectal as needed for seizure with symptoms listed above lasting greater than _____ minutes OR for clusters such as _____ or more seizures in _____ minutes/hours.
- Diastat will be administered according to the attached manufacturer's instructions
- Possible adverse effects and actions to be taken: _____

_____

1. If DIASTAT is given in any instance, staff will call 911, parent/guardian, and school nurse. If parents cannot pick student up within 30 minutes, student will be taken via emergency services to a hospital. Preferred hospital _____
2. If a seizure should occur during bus transportation, 911 will be called.

WPUSD ACTION PLAN FOR A SEIZURE:

1. One staff member stays with the student and protect from injury, placing a pillow or coat under the head
2. A second staff member should call the school nurse, 911, and emergency contacts immediately
3. If there is not a licensed nurse in immediate vicinity, and if authorized by parent, a trained nonmedical volunteer staff member should prepare to administer Diastat per doctor's orders. Do not delay administration to wait for the nurse.
4. Ease the student to his/her side to keep airway open
5. Clear immediate area of any objects that could injure the student, and loosen constrictive clothing
6. Do not attempt to place anything in the student's mouth or retrain student
7. Observe and document breathing pattern, color, level of consciousness, length of seizure, and seizure symptoms on seizure log
8. Student may become incontinent during a seizure, always use universal precautions
9. If needed, administer Diastat per physician orders above and attached manufacturer instructions
10. Stay with the student until the seizure ends, comfort and allow him or her to rest afterwards
11. Student will be directly observed by an adult after Diastat administration until parent picks child up from school or otherwise assumes responsibility for the child
12. Student will be taken to hospital by emergency transport if parents do not pick student up within 30 minutes. Student MAY NOT stay at school after Diastat is given

13. Document observations and time in seizure log, including student response to Diastat

Please check one box to indicate your orders:

☐ I have reviewed and approved the WPUSD protocol as written and I understand that the service may be performed by trained nonmedical school personnel

☐ I have reviewed and approved the WPUSD protocol with attached modifications and I understand that the service may be performed by trained nonmedical school personnel

☐ I do not approve WPUSD's protocol and therefore have attached my alternate written recommendations

My signature below provides the authorization for the above written orders. I understand that assistance with medications will be implemented in accordance with California state laws and regulations. I understand that specialized physical health care services and medication assistance may be performed by unlicensed, designated school personnel after the training by and supervision of the licensed school nurse. If changes are indicated, I will provide new written authorization (may be faxed). Medication is authorized through July 31 of each school year unless otherwise indicated.

Physician Name (please print): _____

Physician Signature: _____ Date: _____

Address: _____

Fax: _____ Phone: _____

Emergency Contact Information: (TO BE COMPLETED BY PARENT/GUARDIAN)

Name: _____ Relationship: _____

Phone: _____ Phone: _____

Name: _____ Relationship: _____

Phone: _____ Phone: _____

Name: _____ Relationship: _____

Phone: _____ Phone: _____

School Nurse Phone: _____

Parent Signature: _____ Date: _____