DIASTAT ADMINISTRATION PLAN

Oakdale Joint Unified School District
168 South 3rd Avenue, Oakdale CA 95361
(209) 848-4884 Fax: (209) 847-0155

Student Name: _____
Birthdate: _____
School: _____ Year: _____
Phone (209) _____ Fax (209) _____

Place Picture Here

☐ BUS RIDER ☐ SPORTS ☐ AFTERSCHOOL PROGRAM/CLUB

Emergency Anti-Seizure Medication Administration: DIASTAT – (DIAZEPAM RECTAL GEL)

HEALTH CARE PROVIDER'S AUTHORIZATION:

- **Please provide the mandatory specific instructions to assist our school staff in emergency anti-seizure medication administration as needed during school hours.**
- **911 will be called following emergency anti-seizure medication administration in accordance with California Ed. Code Section 49414.7**

NOTE: Medication may be administered by non-medical volunteer staff trained in accordance with Education Code Section 49414.7.

EMERGENCY ANTI-SEIZURE MEDICATION ORDERS:

Diazapam Rectal Gel (Diastat): _____

Dosage Prescribed: _____ **Method of Administration:** _____

Frequency to be administered: _____

CIRCUMSTANCES UNDER WHICH THE MEDICATION IS TO BE ADMINISTERED:

Medication should be given for the following:

Type of Seizure: _____

Frequency of Seizure: _____

Length of Seizures: _____

Other: _____

Potential adverse reactions after medication administration and follow-up care: _____

_____

MONITORING AFTER MEDICATION ADMINSTRATION:

Date when emergency anti-seizure medication was last administered: _____

If adverse reactions occurred, what were they? _____

_____

X _____
PARENT/GUARDIAN SIGNATURE **Date**

DIASTAT ADMINISTRATION PLAN *(continued)*

Student Name: _____
Birthdate: _____

ADDITIONAL INFORMATION:

The parent is to provide verbal and written notification to the student's school of the details (time, amount, etc.) if anti-seizure medication has been administered within 4 hours of the start of a school day.

MODIFICATION:

The physician may modify the medication administration in the event of parent notification as described above. Modification as follows: _____
_____
_____

After administration for the emergency anti-seizure medication, 911 will be called and parent/guardian contacted.

EMS protocol may require a parent/guardian to be present to avoid transport to emergency room.

Student will need to go home with parent/guardian after administration of medication.

Emergency anti-seizure medication will not be administered on a school bus. 911 will be called for qualifying seizure activity.

AUTHORIZING SIGNATURES:

_____

Physician's Name (PRINT): **Phone** **Fax**

PHYSICIAN'S STAMP:

-or-

X _____

PHYSICIAN'S SIGNATURE

TO BE COMPLETED BY PARENT OR GUARDIAN:

I request that my child be allowed to take medication at school according to the instruction from the physician. I understand it is my responsibility to bring the medication to school in the original pharmacy container labeled with the student name, medication, dosage and directions (Ed. Code 49423). Determination of the request will be reviewed by the school nurse.

I authorize the school personnel to assist with the above medication for my child as ordered by the physician listed above. I understand that trained, non-medical school personnel may assist with this medication (Ed. Code 49423 and 49480).

This form must be renewed whenever the prescription changes and at the beginning of each school year.

PARENT: I Consent To Communication And Exchange Of Information Between School Nurse And Doctors (Ed.Code 49423.1).

X _____

PARENT/GUARDIAN SIGNATURE **Date**

For School Use Only

Date Reviewed: _____ ***Initials:*** _____

Date Reviewed: _____ ***Initials:*** _____