RCSD ROSEVILLE CITY SCHOOL DISTRICT
Est. 1869

PHYSICIAN'S ORDER FOR THE ADMINISTRATION OF EMERGENCY ANTI-SEIZURE MEDICATION AT SCHOOL

(Form to be completed by Student's Physician)

STUDENT'S NAME:		**SCHOOL:**	
DATE OF BIRTH:		**GRADE:**	

SEIZURE INFORMATION

Seizure Type:	
Frequency of Seizures:	
Seizure Triggers:	
Description of Seizures:	

EMERGENCY ANTI-SEIZURE MEDICATION ORDERS:

MEDICATION: ☐ VALTOCO ☐ NAYZILAM ☐ DIASTAT ☐ MIDAZOLAM ☐ OTHER:_____

ROUTE: ☐ NASAL SPRAY ☐ RECTAL ☐ BUCCAL ☐ ORAL ☐ OTHER:_____

_____**mg** ***dose*** for a seizure lasting greater than _____ ***minutes*** OR for clusters of: _____ ***# of seizures*** or more seizures in _____**minutes** **OR** _____**hours**

Additional interventions If seizure continues longer than _____ ***minutes*** after first dose is given:

If the child has breathing difficulties, a respiratory infection or fever, should the MEDICATION be given? ☐ Yes ☐ No

What action should be taken if the child expels the medication? ☐ None ☐ Other:_____

Possible adverse effects and action to be taken:	
Additional treatment information:	

- **<u>When EMERGENCY ANTI-SEIZURE MEDICATION is given, staff will always call 911.</u>** Parents/Caregiver will be notified immediately.
- **If a seizure should occur while the child is being transported on the school bus, staff will call 911.**

Physician Signature:

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 training by the school nurse. If changes are indicated, I will provide new written authorization (may be faxed). Medication is authorized for one year from date below unless otherwise indicated.

MD/DO/PA Name:		**Stamp:** (or address and phone)	
MD/DO/PA Signature:	**Date:**		

Parent SIGNATURE:

Parent/Guardian (Authorization and Disclaimer): I request that the school assist my child with the medications included in the medication form above in accordance with state laws and regulations. I understand and give my consent for this information to be shared with school, transportation, and emergency personnel as deemed necessary to provide quality of care. In agreeing to have the school administer my child's medication, I voluntarily agree to release, discharge, and hold harmless Roseville City School District and its officers, agents and employees for any and all claims of liability arising out of their negligence,recklessness or any other act of omission which cause my child's illness, injury, death, and damages of any nature in any way connected with the administration of medication. As the parent of the above student, in the event there is no school nurse or other licensed person to administer medication, I give consent for a trained unlicensed assistive person/trained health care aide to administer the prescribed medication to the above student. I understand that I may terminate the consent for the administration of the medication or for otherwise assisting the student in the administration of medication at any time. I authorize the District to communicate with the physician below regarding my child's medical condition and/or medication prescribed for it. This consent is valid for one year from the date below unless otherwise stated and may be revoked at any time.

Parent/Guardian Signature:		Date:	

School Staff SIGNATURES:

Site Nurse Signature:		**Principal Signature:**	