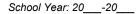




## PHYSICIAN'S ORDER FOR THE ADMINISTRATION OF SEIZURE RESCUE MEDICATION IN THE SCHOOL SETTING (Form to be completed by Student's Physician)

STUDENT'S NAME:			
DATE OF BIRTH:			
SEIZURE INFORMATION		PHOTO HERE	
Seizure Type:			
Frequency of Seizures:			
Seizure Triggers:			
Description of Seizures:			
Medication:	Dose:	Route:	
MEDICATION ORDERS:			
Medication needed for seizure greater than minutes/hours (please circle).	_minutes OR for clusters such as	or more seizures in	
If Seizure continues longer than minutes after first dose is given: Call 9-1-1 Other:			
Additional Treatment Information:			
What action should be taken if the child expels the medication?			
If the child has breathing difficulties (i.e. known asthma), a respiratory infection or fever, should the SEIZURE RESCUE MEDICATION be given?      No			
Possible adverse effects and action to be taken:      Call 9-1-1  Other:			
<ul> <li>If licensed nurse not available when SEIZURE RESCUE MEDICATION is given, staff will call 911. Parents/Caregiver will be notified immediately.</li> </ul>			
If a seizure should occur while the child is being transported on the school bus, the procedure will be to call 911.			
☐ I have reviewed and approved the attached RCSD protocol as written and I understand that the service may be performed by trained non-medical school personnel.			
☐ I have reviewed and approved the attached RCSD protocol with the attached modifications and I understand the service may be performed by trained non-medical school personnel.			
☐ I do not approve RCSD's protocol and, therefore, have attached my alternative 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 the 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.  Alternate medication authorization expiration date:			
PHYSICIAN'S NAME (please print)	PHYSICIAN'S SIGNATURE		
ADDRESS	PHONE	FAX	





## PHYSICIAN'S ORDER FOR THE ADMINISTRATION OF DIASTAT IN THE SCHOOL SETTING (Form to be completed by Student's Physician)

STUDENT'S NAME:			
DATE OF BIRTH:			
SEIZURE INFORMA	TION	PHOTO HERE	
Seizure Type:			
Frequency of Seizures:			
Seizure Triggers:			
Description of Seizures:			
DIASTAT ORDERS:			
DIASTAT AcuDial (diazepam rectal gel):    minutes OR for clusters such as	mg, rectal as needed for seizure las or more seizures in mir	ting greater than nutes/hours (please circle).	
If Seizure continues longer than min     Call 9-1-1    Other: min	utes after first dose is given:		
Additional Treatment Information:			
<ul> <li>What action should be taken if the child has a bowel</li> <li></li></ul>	movement or expels the medication?		
If the child has breathing difficulties (i.e. known asthmule and the second secon	ma), a respiratory infection or fever, shou	•	
<ul> <li>Possible adverse effects and action to be taken:</li> <li>Call 9-1-1  Other:</li> </ul>			
If licensed nurse not available when DIASTAT is giv	en, staff will call 911. Parents/Caregiver	will be notified immediately.	
If a seizure should occur while the child is being	transported on the school bus, the pr	rocedure will be to call 911.	
☐ I have reviewed and approved the attached RCSD protocol as written and I understand the the service may be performed by trained non-medical school personnel.			
☐ I have reviewed and approved the attached RCSD protocol with the attached modifications and I understand the service may be performed by trained non-medical school personnel.			
☐ I do not approve RCSD's protocol and, therefore, hav	e attached my alternative written reco	ommendations.	
My signature below provides the authorization for the above written of accordance with California state laws and regulations. I understand the performed by unlicensed, designated school personnel after the train authorization (may be faxed). Medication is authorized through July 3 Alternate medication authorization expiration date:	hat specialized physical health care services a ling by the school nurse. If changes are indica	and medication assistance may be ated, I will provide new written	
PHYSICIAN'S NAME (please print)	PHYSICIAN'S SIGNATURE	DATE	
ADDRESS	PHONE	FAX	