AUTHORIZATION FOR DIASTAT
WEST VALLEY SCHOOL DISTRICT

This authorization will expire at the end of the school year, or earlier as determined by the health care provider.

THIS PORTION TO BE COMPLETED BY THE PARENT/GUARDIAN

Student _____ **Birth Date** _____ **Grade** ____

Prescribing Health Care Provider's Name/Phone _____

If 911 is called for my child due to seizures at school, I request that the Diastat I provide be given to emergency medical responders, to be administered by a paramedic if one is available and if it is needed. It may also be administered by a licensed nurse working for the school district or by the parent.

I understand that:

1) **Non-medically licensed school staff cannot by State law administer Diastat (for instance, it cannot be administered by teachers, secretaries, principals, etc.)**
2) **By State law, Diastat can be administered by a Medic but not an EMT (Emergency Medical Technician). Depending on location and availability, a paramedic may or may not be part of the 911 response team.**

_____	_____	_____	_____
Date	**Parent/Guardian Signature**	**Home Phone**	**Emergency Phone**

THIS PORTION TO BE COMPLETED BY A LICENSED HEALTH CARE PROVIDER

Diagnosis or condition for which medication is given: SEIZURES

Method of administration: Pre-filled rectal syringe(s) to be administered only by the following if available: a school nurse, a paramedic responding to a 911 call, or the parent

Name of medication: DIASTAT **Dosage:**

To be given AS NEEDED, medical provider to specify indications for usage:

Possible side effects of medication: sedation; respiratory depression

Emergency procedure in case of serious side effects: CALL 911 and the parent/guardian

This authorization is valid: ❒ **For the current School Year; or** ❒ **From** _____ ❒ **To** _____

I authorize that the above named student be administered the above identified medication as directed.

_____	_____	_____
Date	**Health Care Provider Signature**	**Health Care Provider Name (PRINT)**

05/2014
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