

# Administration of Diastat Authorization and Emergency Procedure Parent Consent and Physician Authorization

POWAY UNIFIED SCHOOL DISTRICT  
HEALTH SERVICES  
15250 Avenue of Science  
San Diego CA 92128

Dear Parent/Guardian and Physician of \_\_\_\_\_

California Education Code, Section: 49414.7 allows specialized health care services such as a emergency administration of rectal Diastat gel (Valium) to be performed by a trained designated non-medical school staff member under the indirect supervision of a Credentialed School Nurse (PUSD Resource Nurse).

**Emergency administration of Diastat at school is provided only after the parent and physician complete specific instructions for the current school year.**

1. Parent/Guardian, please read this cover sheet and sign at the bottom. In addition, please sign page 2, Authorization for Medication Administration of Diastat.
2. Physician, please complete the Physician's Authorization for Diastat Administration in the School Setting form (PUSD H-84), providing the credentialed school nurses with specific administration orders.
3. Emergency administration of Diastat will be available to your child **AFTER** completed physician's orders have been received by your school. Parent/Guardian provides all supplies.
4. If you feel your child requires additional assistance during the school day that is not covered by our Administration of Diastat Authorization and Emergency Procedure, please refer to the Annual Notification of Parents'/Students' Rights which can be found on the PUSD website or at your child's school. Your child may qualify for services or accommodations under a Section 504 plan or an Individual Education Plan (IEP).

Thank you for your assistance. If you have any questions, please call to speak to a Resource Nurse at (858) 521-2812.

Please read below and sign:

**I request that this Specialized Physical Health Care service for Emergency Administration of Diastat be made available to my child. I understand that a volunteer non-medical school employee will be trained to administer the Diastat. I authorize my child's physician to communicate with the Resource Nurse when necessary.**

**I understand that my child may qualify for services under a 504 Plan or an Individual Education Plan (IEP) and for additional information I can refer to the Annual Notification of Parents'/Students' Rights found on the PUSD website.**

**PARENT/GUARDIAN SIGNATURE** \_\_\_\_\_ **Date** \_\_\_\_\_



Poway Unified School District  
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**Health Services**

**Authorization for Medication Administration of DIASTAT**  
(EDUCATION CODE SECTION 49423)

This form is valid only for school year:  
\_\_\_\_\_ TO \_\_\_\_\_

I, the undersigned, as legal parent/guardian of \_\_\_\_\_  
Student Name  
\_\_\_\_\_ attending \_\_\_\_\_ request that the following medication(s)  
Birthday School

be made available to my child at the times prescribed \_\_\_\_\_

I understand that only personnel meeting the requirements of California Education and Administration Codes will be performing the above mentioned health care service and will be using only the standardized procedure approved by our physician.

To facilitate the foregoing, I hereby grant permission for the exchange between our physician and the Poway Unified School District of that confidential medical information contained in my child's records necessary to accomplish this service.

If any of the conditions in the Physician's Statement change, a new form must be signed by the parent/guardian and the physician.

I will provide the medicine(s) in the prescription container(s) which is labeled with the name of my child, the prescribing physician name, and amount of medication prescribed.

I will notify the school immediately if the health status of my child changes, we change physicians, or there is a change in or cancellation of the procedure.

I agree to save and hold the district, its officers, employees or agents, harmless from all liability, suits or claims, or whatever nature or kind, which might arise as a result of administering the medication in accord with this request.

I agree to notify school staff if Diastat is given outside the school setting within 4 hours of school attendance.

I give my permission for a trained non medical school employee to administer Diastat.

**Parent Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Home Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_



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15250 Avenue of Science, San Diego CA 92128

**Health Services**

**Physician's Authorization for DIASTAT Administration  
In the School Setting**

STUDENT NAME: \_\_\_\_\_

D.O.B: \_\_\_\_\_ SCHOOL: \_\_\_\_\_ GRADE: \_\_\_\_\_

**PHYSICIAN:**

Please provide the following specific instructions to assist our school staff in Diastat administration as needed during school hours. **911 will be called following Diastat administration.** The parent will be notified and a staff member will observe the student for side effects (listed below), pending arrival of paramedics.

**DIASTAT ORDERS:**

1. Dosage: \_\_\_\_\_ Frequency: \_\_\_\_\_ Route/Rectal \_\_\_\_\_

2. Detailed seizure symptoms requiring Diastat administration: \_\_\_\_\_  
\_\_\_\_\_

3. Frequency and/or length of seizures requiring Diastat administration: \_\_\_\_\_  
\_\_\_\_\_

4. For Cluster Seizures: \_\_\_\_\_ seizures within \_\_\_\_\_  
Number Amount of Time

5. Potential adverse responses to Diastat:

Sleepiness  Shallow breathing/respiratory distress  Other \_\_\_\_\_  
\_\_\_\_\_

➤ **The frequency of Diastat administration must be discussed and agreed upon by parent/guardian, resource nurse, and physician prior to administration. Doses received outside the school setting must be reported to the school if they are given 4 hours prior to school attendance.**

➤ **Diastat will not be administered on a school bus (911 will be called for qualifying seizure activity).**

PHYSICIAN'S NAME (Printed) \_\_\_\_\_

PHYSICIAN'S SIGNATURE \_\_\_\_\_ Date: \_\_\_\_\_

Medical License: \_\_\_\_\_ Phone: \_\_\_\_\_ FAX: \_\_\_\_\_