TEMECULA VALLEY
Unified School District

TEMECULA VALLEY UNIFIED SCHOOL DISTRICT School Year: _____

PHYSICIAN'S AUTHORIZATION FOR EMERGENCY ANTI-SEIZURE MEDICATION ADMINISTRATION

SCHOOL SITE: _____ **FAX#** _____

NAME OF STUDENT	Date of Birth	Grade	School

Education Code 49423 authorizes that any pupil who is required to take, during the regular school day, medication prescribed for him/her by a physician, may be assisted by the school nurse or other designated personnel if the school district receives (1) a written statement from such physician detailing the method, amount, and time schedules by which such medication is to be taken and (2) a written statement from the parent/guardian of the pupil indicating the desire that the school district assist the pupil in the matter set forth in the physician's statement.

- The parent or adult representative designated by the parent must bring all prescribed medications to school in its prescription-labeled container.
- Parent/guardian may pick up unused medications at the close of the school year. Medication remaining after the last day of school will be properly discarded.

Medication prescribed by an authorized health care provider, including, but not limited to, emergency anti-seizure medication for a student who suffers epileptic seizures, may be administered by the school nurse or other designated school personnel only when the Superintendent or designee has received written statements from both the student's parent/guardian and authorized health care provider. *(Education Code 49414.7, 49423, 5 CCR 600).* **T**
Transportation: To protect the privacy and safety of all students, it is Temecula Valley Unified School District's transportation protocol to pull over, call 9-1-1, and provide First Aid for seizure emergencies. If physician determines it is necessary to administer emergency anti-seizure medication on the bus, please indicate below in the space provided including medical rationale.
Diastat Administration:

- **Temecula Valley Unified School District requires the administration of the first dose of Diastat to be administered at home if the student is taking Phenobarbital**
- **Diastat is not to be used to treat more than five (5) episodes per month, and no more than one (1) episode every five (5) days**
- **9-1-1 will be called following Diastat administration OR the administration of any Emergency Anti-Seizure medication**

- Student has previously received (list medication) Emergency Anti-Seizure Medication _____ Date: ____ Adverse effects: Yes No MD Initials ____
- Emergency Anti-Seizure Meds on Bus: _____ Medical Rationale: _____ MD Initials _____

I. **PRESCRIBED MEDICATION REQUIRED TO BE ADMINISTERED DURING SCHOOL HOURS** (THIS SECTION IS TO BE COMPLETED BY PHYSICIAN)

Name of Medication:	Dosage
Frequency of administration	Specific description of seizures requiring medication administration
Duration of Seizure Requiring Medication administration	Route of administration
Number of Cluster Seizures _____ within _____minutes	Specific description of Cluster Seizures
Precaution-possible untoward reactions	Date to be discontinued
Name of physician (Please print)	Physician's telephone number Fax number
Physician's signature	NPI: Date:

II. **THIS SECTION IS TO BE COMPLETED BY PARENT/GUARDIAN** **(PARTS I AND II MUST BE COMPLETED)**

I give permission for my child to receive the above medication at school according to the district board policy and administrative regulations, and agree to release, indemnify and hold harmless Temecula Valley Unified School District, its *board* member, officers, agents & employees from lawsuits, claims, demands, actions or expenses that may arise against them for administering medication as set forth in accordance with the provision of part I above.

- I understand that emergency anti-seizure medication may be administered by the school nurse or other designated trained unlicensed school personnel. *(Ed Code 49414.7, 49423)*
- I agree to allow communication and the exchange of pertinent medical information between medical providers and the School Nurse involved with my child's medical care.
  I will notify the Health Office/ School Nurse immediately if emergency anti-seizure medication is administered to my child outside of the school setting, health status of my child change, change in physician(s), or change or cancellation of the medication.
- I understand that I may terminate consent for such administration of medication at any time, in writing.

Signature of Parent/Guardian: _____ Relationship: _____ Date: _____