SADDLEBACK VALLEY UNIFIED SCHOOL DISTRICT HEALTH SERVICES
SEIZURE EMERGENCY DIASTAT CARE PLAN

Please accept CHOC and Kaiser Seizure Care Plans and Treatment Orders, for all others, see below Care Plan and Treatment Orders.

Student:_____ **DOB:** _____

Grade: _____ **School:** _____

CONTACT INFORMATION:

Parent/Guardian:_____Hm:_____ Cell_____Wk_____

Parent/Guardian:_____Hm:_____ Cell_____Wk_____

Neurologist _____Phone_____Fax: _____

SEIZURE HISTORY:

When was child diagnosed with seizures or epilepsy?_____Date of last seizure: _____

Type of seizure: _____ How often do seizures occur? _____

Description the seizures: _____ Typical seizure length (time)? _____

What will trigger a seizure?_____

Warning signs before seizure?_____

Student's behavior **during** a seizure?_____

Student's behavior **after** a seizure?_____

Does child wear a helmet at school? _____ Does child have a Vagus Nerve Stimulator? _____

Daily Seizure Medication:

_____

Has student previously been administered emergency Diastat? Yes No

If yes, most recent date _____

If yes, list any adverse reaction _____

If yes, most recent date _____

Allergies: _____

Any other significant Medical History: _____

_____

SADDLEBACK VALLEY UNIFIED SCHOOL DISTRICT HEALTH SERVICES
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Student: _____ **DOB:** _____ **Grade:** _____ **School:** _____

SEIZURE EMERGENCY

- A seizure **lasting longer than 5** minutes OR **repeated seizures** without regaining consciousness.
- **First time seizure**, is injured during a seizure or prior to, has diabetes, has breathing difficulties, or has seizure in water.

EMERGENCY TREATMENT PROTOCOL DIASTAT© * See page 3 for specific emergency protocol

Call 911 Immediately at all times when Diastat© administered

Diastat© Side-Effects: *Drowsy, sleepy, unsteady, sedated, fatigued, poor coordination, behavior changes*

After Diastat© given and/or if 911 called

- Keep child on left side in "recovery position"
- Monitor for changes in breathing pattern or color changes to lips, face or other areas
- Protect head and keep airway open
- Keep child safe until help arrives
- Child may vomit, have a bowel movement (stool), or urinate during or after a prolonged seizure.
- Do not put anything inside of mouth
- Do not restrain or hold down
- Have Office staff **CALL 911** and deploy on-site trained volunteer.
- Call School Administrator and Notify Parents/caregiver immediately.
- Per California Education Code 49474.7: Calling 911 shall Not require a child to be transported to an emergency room. However, the child will be transported to nearest receiving hospital, if determined to be necessary by 911 emergency personnel. Child will be accompanied by a school staff member if parent is unavailable.
- Parents/caregiver should receive a note/copy of the "Seizure Record" sent home with child.
- If Diastat© administered, recommend child go home with parent/caregiver due to direct observation requirements. Child to be observed by an adult for 4 hours after Diastat© given.
- Document symptoms and pattern of seizure activity: how long (timed by clock), steps were taken, any injury or unusual occurrence, and when parent was notified on Seizure Record, or on Med log.

SADDLEBACK VALLEY UNIFIED SCHOOL DISTRICT HEALTH SERVICES
SEIZURE EMERGENCY DIASTAT CARE PLAN

Student: _____ **DOB:** _____ **Grade:** _____ **School:** _____

To be completed by Neurologist

EMERGENCY TREATMENT PROTOCOL" for this student:

☐ **Administer Diastat AcuDial ____mg Rectal Gel**

Give ____**mg per rectum for seizure type:**

☐ **A *seizure*** *(type: _____) lasting* **>** *(longer than) 5 minutes*.

☐ **A *seizure*** *(type: _____) lasting* **<** *(less than) ___ minutes.*

☐ **A cluster of > ___ seizures** *(type: _____)* occurring in a 1 (one) hour time period.

Minimum time between Diastat doses is **4 hours**.

Maximum number of doses per day/24 hours **is:** ____ **hours.**

Activity Restrictions

☐ No Restrictions

☐ No Swimming

☐ No Contact Sports

☐ No use of power tools/equipment

☐ Other: _____

Authorized Health Care Provider Authorization for Management of Seizures at School

My signature below provides authorization for the above written order, including administration of Diastat. I understand that all procedures will be implemented in accordance with state laws and regulations. I understand that specialized physical health care services may be performed by unlicensed designated school personnel under the training and supervision provided by the District Nurse or other duly qualified supervisor of health. This authorization is for a maximum of one year. If changes are indicated, I will provide new written authorization (may be faxed).

Printed name of Neurologist/ Physician: _____

Address: _____

Phone: _____ Fax: _____ **Office Stamp**

Neurologist/ Physician Signature: _____ Date: _____

SADDLEBACK VALLEY UNIFIED SCHOOL DISTRICT HEALTH SERVICES
SEIZURE EMERGENCY DIASTAT CARE PLAN

Student: _____ **DOB:** _____ **Grade:** _____ **School:** _____

To be completed by Neurologist

SEIZURE TYPE

Student may experience some or all of the listed symptoms during a specific seizure.

Type of seizure (s)	Description*
☐ Absence	● Staring; eye blinking; loss of awareness
☐ Atonic (Drop Attack)	● Loss of muscle control; may go limp or fall to the ground; unresponsive
☐ Complex partial	● May be confused or fearful; not be fully responsive/unresponsive; have purposeless, repetitive movements
☐ Generalized Tonic Clonic	● Convulsions; stiffening; unconscious; Breathing may be shallow; lips or skin may have a bluish color; Confusion, weariness or belligerence when seizure ends
☐ Myoclonic	● Sudden jerks of head, arms, legs, may occur several times in a row or "cluster": May be strong enough to fall to the ground.
☐ Simple Partial	● Remains conscious; Distorted sense of smell, hearing, sight; Involuntary rhythmic jerking/twitching on one side.
☐ Tonic	● Sudden stiffening of body; may be rigid, arms and legs may extend outward
☐ Spasms	● Sudden flexion or extension movements of arms and/or legs, mimics a startle response seen in infants; Typically occur several times in a row in a quick pattern and "cluster".

Printed name of Neurologist: _____

Address: _____

Phone: _____ Fax: _____ **Office Stamp**

Neurologist Signature: _____ Date: _____

SADDLEBACK VALLEY UNIFIED SCHOOL DISTRICT HEALTH SERVICES
SEIZURE EMERGENCY DIASTAT CARE PLAN

Student:_____ **DOB:** _____ **Grade:** _____ **School:**_____

Parent Consent for Management of Seizures at School

I (We), the parent/guardian of the student named below, request that the following regimen for Management of Seizures in school be administered to our child in accordance with state laws and regulations. I will:

1. Provide the prescribed medication necessary supplies and equipment.
2. Provide a 3 day emergency supply of medication.
3. Notify the school if there is a change in student health status or change of physician.
4. Notify the school immediately and provide new consent for any changes in doctor's orders.
5. Notify the school if student has received emergency medication or anti-seizure medication in the last 24 hours.

California Education Code Section 49423 allows the district nurse or other designated non-medical personnel to assist students who are required to take medication during the school day. This service is provided to enable the student to remain in school and to maintain, or improve his/her potential for education and learning.

I request that medication be administered to my child in accordance with our authorized health care provider's written instructions. I understand that designated non-medical school personnel may assist in carrying out written orders under supervision of a qualified District Nurse. I will notify the school immediately and submit a new form if there are changes in medication dosage, time of administration and/or the prescribing authorized health care provider. I give my permission for the District nurse to exchange verbal and written medication-related information with the authorized health care provider.

The District Nurse may counsel appropriate school personnel regarding the medication and its possible effects.

Parent Signature:_____ **Date:**_____

District Nurse Signature:_____ **Date:**_____

Saddleback Valley Unified School District
Medication Authorization Form

E 5141.21

PARENT/GUARDIAN AND AUTHORIZED HEALTH CARE PROVIDER REQUEST FOR MEDICATION

Name of Student:_____ Birthdate: _____

School:_____ Teachers Name:_____ Grade/Track: _____

PARENT/GUARDIAN REQUEST FOR THE ADMINISTRATION OF MEDICATION
PRESCRIPTION AND NONPRESCRIPTION

California Education Code Section, 49423 allows the school nurse or other designated non-medical school personnel to assist students who are required to take medication during the school day. This service is provided to enable the student to remain in school and to maintain, or improve his/her potential for education and learning.

I request that medication be administered to my child in accordance with our authorized health care provider written instructions. I understand that designated non-medical school personnel may assist in carrying out written orders under supervision of a qualified School Nurse. I will notify the school immediately and submit a new form if there are changes in medication, dosage, time of administration, and/or the prescribing authorized health care provider. I give permission for the school nurse to exchange medication-related information with the authorized health care provider. The school nurse may counsel appropriate school personnel regarding the medication and its possible effects.

Emergency medicine such as EpiPen or inhalers may be carried by the student when recommended by an authorized health care provider and parent. Back-up medication should be kept at school for emergency use. I release the district and school personnel from civil liability if my child suffers an adverse reaction as a result of self-administering medication.

Parent/Guardian Signature:_____ Date:_____

Telephone: (Work)_____ (Home) _____

AUTHORIZED HEALTH CARE PROVIDER REQUEST FOR ADMINISTRATION OF MEDICATION

Reason for Medication: _____

Medication:_____ Dose:_____ Route:_____ Time: _____

If PRN: Amount of time between doses_____ Maximum number of doses_____ per day.

Possible medication reactions: _____

Instructions for emergency care _____

By signing below, I verify the information is correct and medication may be administered by a trained, unlicensed professional.

Authorized Health Care Provider Signature: _____

Authorized Health Care Provider Name (print clearly):_____

Telephone_____

Provider NPI # _____

Date of Request: _____

Date to Discontinue Medication:_____

Office Stamp

Regarding EpiPen/Inhalers: It is my professional opinion that this student should be permitted to carry/self administer this emergency Inhaler/EpiPen. This student has been instructed in, and demonstrates an understanding of proper usage.

Health Care Provider Initials _____

SCHOOL USE:
Reviewed by:_____ Date: _____

This request is valid for a maximum of one year.

Revised 8-20-2020 es

Saddleback Valley Unified School District
Medication Authorization Form

E 5141.21

PARENT NOTIFICATION FOR THE ADMINISTRATION OF MEDICINE AT SCHOOL

***Name of Student**:* _____

TO THE PARENT/GUARDIAN:

Medical treatment is the responsibility of the parent/guardian and an authorized health care provider. An authorized health care provider is an individual who is licensed by the State of California to prescribe medication. **Medications, both prescription and over the counter**, may be given at school when it is deemed absolutely necessary by the authorized health care provider that the medication be given during school hours. **The parent/guardian is urged, with the help of your child's authorized health care provider, to work out a schedule of giving medication at home whenever possible.**

California Education Code, Section 49423 allows school personnel to assist in carrying out an authorized health care providers written orders. Designated non-medical school personnel may be assisting with your child's medication. They will be trained and supervised by credentialed school nurses. Medication will be safely stored and locked or refrigerated, if required.

Emergency medicine such as EpiPens or inhalers may be carried by the student **when recommended by a authorized health care provider and parent**. When appropriate, the school nurse will evaluate the student's ability to safely self-administer the medication based on written district guidelines. (Title 5). Back up medication should be kept at school for emergency use. Students who have a serious medical condition (diabetes, epilepsy, etc.) should have an emergency supply of their prescription medication at school with the appropriate consent forms in the event of a disaster.

IF MEDICATION IS TO BE ADMINISTERED AT SCHOOL, ALL OF THE FOLLOWING CONDITIONS MUST BE MET:

1. A written statement signed by the licensed authorized health care provider/dentist specifying the reason for the medication, the name, dosage, time, route, side effect; and specific instructions for emergency treatment must be on file at school.
2. A signed request from the parent/guardian must be on file at school.
3. Medication must be delivered to the school by the parent/guardian or other responsible adult.
4. Medication must be in your child's original, labeled pharmacy container written in English.
5. All liquid medication must be accompanied by an appropriate measuring device.
6. If pill splitting is required to obtain the correct dose of medication to be administered, only pills that are scored may be split, scored pills may be split in half only, and a commercial pill splitting device should be used for correct splitting.
7. Over the counter medication that has been prescribed by an authorized health care provider must be in its original container.
8. A separate form is required for each medication.

NOTE: Whenever there is a change in medication, dosage, time, or route the parent/guardian and authorized health care provider must complete a new form. Please discuss your authorized health care provider's instructions with your child, so that he/she is aware of the time medication is due at school**.**

This request is valid for a maximum of one year.

Revised 8-20-2020 es