RCSD ROSEVILLE CITY SCHOOL DISTRICT
Est. 1869

School Year: 20___-20___

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:		PHOTO HERE
DATE OF BIRTH:		
SEIZURE INFORMATION		
Seizure Type:		
Frequency of Seizures:		
Seizure Triggers:		
Description of Seizures:		
Medication:	**Dose:**	**Route:**

MEDICATION ORDERS:

- Medication needed for seizure greater than _________minutes OR for clusters such as __________ or more seizures in _________ minutes/hours (please circle).
- 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? ☐ Yes ☐ No ____
- Possible adverse effects and action to be taken: ____
  ☐ Call 9-1-1 ☐ Other: ____
- If licensed nurse not available when SEIZURE RESCUE MEDICATION is given, 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 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

RCSD ROSEVILLE CITY SCHOOL DISTRICT
Est. 1869

School Year: 20___-20___

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

STUDENT'S NAME:	PHOTO HERE
DATE OF BIRTH:	
SEIZURE INFORMATION	
Seizure Type:	
Frequency of Seizures:	
Seizure Triggers:	
Description of Seizures:	

DIASTAT ORDERS:

- DIASTAT AcuDial (diazepam rectal gel): ___________mg, rectal as needed for seizure lasting greater than _________minutes OR for clusters such as __________ or more seizures in _________ minutes/hours (please circle).
- 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 has a bowel movement or expels the medication?
- ____
- If the child has breathing difficulties (i.e. known asthma), a respiratory infection or fever, should the DIASTAT be given?
  ☐ Yes ☐ No ____
- Possible adverse effects and action to be taken: ____
- ☐ Call 9-1-1 ☐ Other: ____
- If licensed nurse not available when DIASTAT is given, 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 procedure 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, 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
_______________ DATE

_______________________________ ADDRESS
_______________ PHONE
_______________ FAX