DIASTAT

ST. LANDRY PARISH SCHOOL BOARD
PUPIL APPRAISAL CENTER
127 BLAIR STREET
OPELOUSAS, LA 70570

Dear Parent/Guardian:

We would like to inform you of the school policies that have been in place to ensure the health, safety and welfare of children who need medicine during the school day. Our school board requires that the following forms must be on file in your child's health record before we begin to give any medicine at school.

1. Consent from signed and dated by parent or guardian.
2. Medication order form filled out, signed, and dated by child's doctor.
3. Emergency plan filled out, signed and dated by parent.
4. Call school nurse for appointment time before reporting to the school.

When your child needs medication to be given during the school day, please refer to these simple rules to help make it a more pleasurable experience.

1. Medication must be brought in by a parent/guardian only. **No students are allowed to bring medication onto campus**. Only a 35 day supply of medicine will be accepted.
2. Each school has a designated time of receiving medication. Please check with your child's school personnel for these times.
3. Each school has designated times for given medications; please help the school personnel by following this policy.
4. Antibiotics, skin creams, pain medicine, or a.m. doses will have to be approved by the school nurse prior to administering in schools.
5. All doctor's orders and medicine bottle labels must match.
6. **Must meet with school nurse before medication can be given (exception: asthma inhalers and epi pens)**

I have read and understand the above rules that must be complied with for my child to receive medications at school.

_____ _____

Parent's/Guardian's Signature Date

Thank you for your cooperation in helping us give your child's medicine safely.

_____

School Nurse's Signature

Alvado C. Willis
Director of Special Education

ST. LANDRY PARISH SCHOOL BOARD
PARENT/GUARDIAN WRITTEN REQUEST AND CONSENT
FOR MEDICATION ADMINISTRATION

General Information

Name of Student: _____ School: _____
Date of Birth: _____ Sex: _____ Grade: _____ Teacher_____
Name of Parent / Guardian: _____
(Please Print)
Telephone Number – (Home) _____ (Work) _____
Telephone Number – (Where parent/guardian can be reached in case of emergency):_____
Other Persons to be notified in case of emergency if parent/guardian is unavailable:
Name:_____ Telephone:_____
Relationship:_____
Name:_____ Telephone:_____
Relationship:_____

My son / daughter is currently receiving the following medications: Please list all medications the child is receiving, including those given during the school day:
1._____ 2._____ 3._____ 4._____

My son / daughter is known to have the following allergies: _____

******** **********

Consent

1. I hereby give permission for the school nurse or the designated unlicensed school personnel to give the following medicine:_____ prescribed.
(Name of Medication)

_____ _____
(Licensed Prescriber) (Name of Student)

2. I give permission for my son / daughter to self-administer medication if the school nurse determines it is safe and appropriate in the school: Yes _____ No____

I acknowledge that the St. Landry Parish School Board and its employees shall incur no liability as a result of any injury sustained by the student from the self-administration of medications used to treat asthma or anaphylaxis. The parent or legal guardian shall indemnify and hold harmless the St. Landry Parish School Board and its employees against any claims that may arise relating to the self-administration of medications used to treat asthma or anaphylaxis. (***Health and Safety, Bulletin 135, Louisiana Department of Education***)

Signature of Parent/Guardian: _____
Signature of Student: _____

3. I give permission to the school nurse to obtain information relative to the prescribed medication from the above named physician and share it with appropriate school personnel (such as adverse effects).
Yes ___ No ___ Restrictions on release: _____

4. **I have administered the initial dose ordered at home and have allowed sufficient time for observation of adverse reactions before asking school personnel to administer the medication.**
Yes___ No___

5. I understand if there is a change in physicians, the medication order is no longer valid:
Yes___ No___

(Please note: I understand that I may retrieve the medication from the school at any time and that the medicine will be destroyed if it is not picked up within one week following termination of the order or _____ beyond the close of school.)

Signature of Parent / Guardian _____

Relationship to Student _____ Date:_____

ST. LANDRY PARISH SCHOOL BOARD
SCHOOL NURSE PROGRAM
UNAVAILABLE MEDICATION TIMES

Date: _____

Student Name: _____

Date of Birth: _____

MD: _____

Please be aware that medications are unavailable after the school office closes and on the school bus (including Diastat®, Epi-Pens, Glucagon, and Inhalers), unless the student has orders to self-carry & administer medication without supervision.

_____ _____

Licensed Provider's Signature Date

_____ _____

Parent Signature Date

_____ _____

RN Signature Date

Physician's Order for Administration of Diastat® in School

St. Landry Parish School Board Pupil Appraisal Center
127 Blair Street
Opelousas, LA 70570
Phone: 337-948-3646 Fax: 337-948-3644

Diastat®, rectal diazepam, is FDA approved for out-of-hospital treatment of prolonged seizures or cluster seizures (acute repetitive seizures). In accordance with the Louisiana Policy on Medication Administration in Public Schools, Diastat® may be administered as a rescue drug in seizure emergencies by the registered or licensed practical nurse or trained unlicensed school board employee. It is strongly recommended that the first administration of Diastat® not occur at school, as this will enable school personnel to confidently identify the student's seizure and anticipate the student's response to Diastat®. It is also recommended that only students with significant risk of seizure emergencies, that is students who have received Diastat® within the past 12 months, receive Diastat in school settings.

Please complete the Physician's Order for Administration of Diastat® in School, and on your prescription indicate the dose and time of administration as stated on this form. Thank you for your assistance.
_____, School R.N.

Student's Name _____ **Date of Birth** _____

School _____ **Grade** _____

PHYSICIAN'S ORDER FOR ADMINISTRATION OF DIASTAT® IN SCHOOL

Date this student last received Diastat®: _____

Description of the seizure for which Diastat® is ordered

(Please provide a student specific description that will permit identification of the seizure.)

1. The student has a warning before the seizure □ No □ Yes (please specify)_____
2. This student's seizure begins with
   - □ unresponsive staring
   - □ deviation of head or eyes to □ left □ right
   - □ stiffening or twitching on □ left □ right □ both sides at the same time?
1. This student's seizure progresses with
   - □ spread of stiffening and/or jerking to □ left □ right □ both sides of the body
   - □ persisting unresponsiveness without convulsive movements
   - □ cyanosis _____ □ other, please specify _____

Dosing and time of administration of Diastat®

Administer by rectum _____mg of Diastat® after seizure of _____ minutes duration, or if _____ (indicate number) seizures occur within _____ (indicate period of time).

Dosing of Diastat®

Dosing will follow FDA- approved labeling. Please refer to the dosing chart:

2-5 years (0.5 mg/kg dose			6-11 years (0.3 mg/kg dose)			12+ years (0.2 mg/kg dose)		
Weight		Dose	Weight		Dose	Weight		Dose
Kg	Lbs	Mg	Kg	Lbs	Mg	Kg	Lbs	Mg
6-11	13-23	5	10-18	22-41	5	14-27	30-60	5
12-22	26-49	10	19-37	42-82	10	28-50	61-111	10
23-33	50-74	15	38-55	83-122	15	51-75	112-166	15
34-44	75-98	20	56-74	123-164	20	76-111	167-244	20

In accordance with labeling, Diastat® can be administered only once every 5 days or 5 times within one month.

Notification

I wish to be notified if the student is brought by ambulance to the hospital □ No □ Yes
I wish to be notified if Diastat® is administered □ No □ Yes

Concomitant medications: (helpful in case student is brought to hospital) _____

Other Comments: _____

Physician's Name (printed) _____ **Physician's signature** _____

Address _____

Office Phone _____ **Emergency Phone** _____ **Office Fax** _____

State License Number _____ **Date** _____

_____

The Physician's Order for Diastat®

A. The **Physician Diastat Order®** should be consistent with FDA-approved criteria and the labeling on the Diastat package provided by the student's family.

B. The school RN must receive a detailed **Physician's Diastat® Order** which includes, but is not limited to, the following:

1. The **dose** of Diastat® prescribed
2. The **specific description** of the seizure for which Diastat® is prescribed
3. The **specific time** to administer Diastat®. The order must state a specific time after seizure onset, or within a certain period of time, or after a specified number of seizures occurring over a specific time interval (for example, after a seizure of 5 minutes duration, or within 5 minutes of seizure onset, or after 2nd seizure occurring within an hour.)
4. The **frequency** of Diastat® administration at home and at school should be in accordance with the FDA-approved labeling, and should not be administered more than one time every five-day period, and not more than five times per month. This information must be obtained from parents/guardians.
5. **Documentation from the prescribing practitioner** that the student has previously received Diastat® without adverse effects prior to its use in the school setting
6. **The date and time** that Diastat® was administered within the past 12 months
7. **A list of other medications** prescribed for the student

ST. LANDRY PARISH SCHOOL BOARD

EMERGENCY PLAN

Name of Student_____ Teacher_____ Grade_____

Name of Parent / Guardian_____

Phone Numbers: Home _____ Work _____ Cell _____

Alternate Adult Contact Person: (1) _____ Phone#_____

Alternate Adult Contact Person: (2) _____ Phone#_____

Relationship of alternate persons to student: (1)_____ (2)_____

Physician's Name _____ Phone Number_____

Poison Control Number: 1-800-256-9822

Student's allergy history: _____
(List all medications, food, plants, insects, etc. that your child is allergic to)

Field Trip Designated Person: Trained Personnel_____

Parent/Guardian_____

Alternate Adult Person_____

I am aware that if my child has an emergency in school and I am not available, the school principal or alternate will have my child transported to the emergency room, and I will be responsible for payment of emergency care.

IF AN EMERGENCY OCCURS, SCHOOL PERSONNEL WILL DO THE FOLLOWING:

1. **If the emergency is life threatening, immediately call 9 – 1 – 1.**
2. **Stay with the student, or designate another adult to do so.**
3. **Contact the parent/guardian, or alternate adult (named above).**
4. **Follow school protocol.**
5. **Contact school nurse at your child's school.**

_____ _____

Signature of Parent/Guardian Date Signed

STUDENTS WITH SPECIAL HEALTH CARE NEEDS

TRANSPORTATION PLAN

Student's Name _____
School _____ Teacher's Name _____
School Bus# _____ a.m. _____ p.m. Bus Driver's Name _____
Parent/Guardian Name _____
Address _____
Telephone (home) _____ (cell) _____

Work Phone (dad) _____ (mom) _____

Babysitter's Name _____ Phone _____

Babysitter's Address _____

Disability / Diagnosis _____

Medication(s) _____

Side effects of Medication(s) _____

1. Mode of transportation on bus: (check one)
   _____wheelchair _____car seat _____seat belt _____chest harness _____regular seat

2. Walks up bus stairs independently: _____yes _____no

3. List student's method of communication _____

4. List any behavioral difficulties student displays _____

5. List equipment that must be transported on bus (such as oxygen, life sustaining equipment, wheelchair equipment, climate control, etc.) _____

6. Wheelchair restraint checklist (check all that apply)
   _____seat belt _____chest harness on _____wheelchair brakes on
   _____tray off _____headrest and hip abductor in place _____other: _____

_____ _____
School Signature Date

ST. LANDRY PARISH SCHOOL BOARD
PUPIL APPRAISAL CENTER
127 BLAIR STREET
OPELOUSAS, LA 70570

Activity Restrictions

Date: _____

Student's Name: _____

Medical Condition: _____

Can the student participate in Physical Education Classes?
____Yes ____No

Are there any activity restrictions for this student?
____ Yes ____No

What are the student's limitations/restrictions? Please list them:

_____

_____

_____

_____ _____
Physician's Name (Print) Physician's Signature

_____
Physician Address

_____ _____
Telephone Number Fax Number

Thank you for your time and assistance in completing this documentation.

St. Landry Parish School Nurses