PSUSD
PALM SPRINGS UNIFIED SCHOOL DISTRICT

Parent Consent and Healthcare Provider Authorization for
EMERGENCY ANTI-SEIZURE MEDICATION ADMINISTRATION
at School and School-Sponsored Events

Student:	**DOB:**	**Grade:**
School:	**Phone:**	**Fax:**

PLEASE REVIEW AND CHECK THE APPROPRIATE BOX TO INDICATE AUTHORIZATION.

1. Check one of the boxes below:

□ I have reviewed and approved the attached standardized procedure as written
□ I have reviewed and approved the attached standardized procedure as written with the attached modifications
□ I do not approve of the standardized procedure. I have attached my alternative procedure and recommendations

2. Name of medication and dosage prescribed

Valtoco Nasal Spray	**Nayzilam Nasal Spray**
☐**5 mg** = 1 spray device holding 5 mg of diazepam, in 1 blister pack ☐**10 mg** = 1 spray device holding 10 mg of diazepam, in 1 blister pack ☐**15 mg** = 2 spray devices, each holding 7.5 mg of diazepam, in 1 blister pack ☐**20 mg** = 2 spray devices, each holding 10 mg of diazepam, in 1 blister pack	☐**5 mg** = 1 spray device holding 5 mg of midazolam, in 1 blister pack **Diazepam Rectal Gel** ☐**7.5 mg prefilled AcuDial** ☐**10 mg prefilled AcuDial** ☐**15 mg prefilled AcuDial** ☐**Other dosage**_____
☐At onset of seizure ☐At _____minutes after seizure begins ☐Cluster Seizure: (#)_____seizures within_____minutes ☐Treat no more than ___episodes per month or not more than 1 episode every ____days ☐Call 911 at onset of seizure or after ____minutes ☐Call Parent	

3. PRN needed for (specify type of seizure and seizure symptoms) _____

4. Special Instructions: (Example: Oxygen Administration)_____

Authorized Healthcare Provider Authorization for
NASAL BENZODIAZEPINE ☐VALTOCO ☐ NAYZILAM ADMINISTRATION ☐ Diazepam Rectal Gel in School Setting

My signature below provides authorization for the above written orders. I understand that all procedures will be implemented in accordance with state laws and regulations. I understand that specialized physical healthcare procedures may be performed by unlicensed designated school personnel under the training and supervision provided by the school nurse. This authorization is for a maximum of one year. If changes are indicated, I will provide the written authorization. Authorizations may be faxed.

***Authorized Healthcare Provider Name:**_____ **Signature:** _____ **Date:** _____

Phone: _____**Address:** _____ **City** _____ **Zip** _____

***Nurse Practitioner, Nurse Midwife, Physician Assistant: Furnishing Number** _____

Parent Consent for Authorization for
NASAL BENZODIAZEPINE ☐VALTOCO ☐ NAYZILAM ADMINISTRATION ☐ Diazepam Rectal Gel in School Setting

I, the undersigned, the parent/guardian of the above named student, request that the specialized physical healthcare procedure be administered to my child in accordance with state laws and regulations. I will :

1. provide the necessary supplies and equipment;
2. notify the school nurse if there is a change in child's health status, or attending healthcare provider; and
3. notify the school nurse immediately and provide new written consent/authorization for any changes in the above authorization.
4. provide new written consent/authorization yearly.

I give consent for the school nurse to communicate with the authorized healthcare provider when necessary.

Parent/Guardian (Print Name): _____ **Signature:** _____ **Date:** _____

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

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***Authorized Healthcare Provider Name:**_____ **Signature:** _____ **Date:** _____

Phone: _____**Address:** _____ **City** _____ **Zip** _____

***Nurse Practitioner, Nurse Midwife, Physician Assistant: Furnishing Number** _____

Consentimiento y Autorización de los Padres para la
ADMINISTRACIÓN de BENZODIAZEPINA NASAL ☐ VALTOCO ☐ NAYZILAM ☐ Diazepam Rectal Gel en el entorno escolar

Yo, el abajo firmante, el padre / tutor del estudiante arriba mencionado, solicito que el procedimiento especializado para el cuidado de la salud física se le administre a mi hijo / hija en acorde con las leyes y reglamentos estatales. Yo:

1. proporcionaré los suministros y equipos necesarios;
2. notificaré a la enfermera de la escuela si hay un cambio en el estado de salud del niño / niña o del proveedor de atención médica que lo atiende; y
3. notificaré a la enfermera de la escuela de inmediato y proporcionaré un nuevo consentimiento / autorización por escrito para cualquier cambio de la autorización anterior.
4. proporcionaré un nuevo consentimiento / autorización por escrito anualmente.

Doy mi consentimiento para que la enfermera de la escuela se comunique con el proveedor de atención médica autorizado cuando sea necesario.

Padre / Tutor (nombre en letra de molde): _____ **Firma:** _____ **Fecha:** _____

Teléfono del hogar: _____ **Teléfono del trabajo:** _____ **Celular:** _____

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