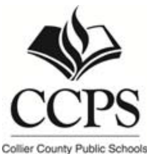


PHYSICIAN'S PLAN OF CARE

FOR ADMINISTRATION OF INTRANASAL NAYZILAM (MIDAZOLAM)

Student's Name: ________________________________ Student Number: ______________

Date of Birth: _________________ Teacher: _______________________ Grade: ____________

Allergies: ____

It is necessary for the above named student to have Nayzilam (Midazolam) ________ mgs administered in the event of seizure activity as described here:____

ICD 10 Code _____________

ADMINISTRATION PROTOCOL:

1. **When nurse is not present:**
   a. Trained school personnel will give Nayzilam (Midazolam):
      ☐ At onset of any seizure.
      ☐ At _________ minutes after onset of seizure.
      ☐ Other ____

911 will be called upon administration of Intranasal Nayzilam (Midazolam) by trained school personnel if nurse is not present.

2. **When nurse is present:**
   a. Give Intranasal Nayzilam (Midazolam):
      ☐ At onset of any seizure.
      ☐ At _________ minutes after onset of seizure.
      ☐ Other ____

   b. Call 911:
      ☐ At onset of any seizure.
      ☐ At _________ minutes after onset of seizure.
      ☐ At _________minutes after Intranasal Nayzilam (Midazolam) is given, if seizure activity is still present

3. During transport:
   a. Since Intranasal Nayzilam (Midazolam) cannot be given on a school bus or while in transit, when should 911 be called?
      ☐ At onset of any seizure.
      ☐ At _________ minutes after onset of seizure

STANDARDIZED PROCEDURES:

☐ I have reviewed and approve the proposed plan of care for this student.
☐ I have reviewed and approve the proposed plan of care for this student with the specific modifications I have Included below:

1. Precautions, possible side effects to observe: ____
2. Recommended interventions for side effects: ____
3. The above treatment(s)/intervention(s) are to be continued until ______________________________.
   (Expiration Date)

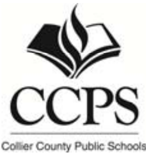
I give permission for my child's doctor to be contacted for information regarding the administration of this medication.

________________________ ________________________ ________________
Physician's Printed Name | Physician's Signature | Date

____ ____________ ____________
Physician Office Address | Phone | Fax

________________________ ________________________ ________________
Parent/Guardian Printed Name | Parent/Guardian Signature | Date

Reviewed by ______________________________________ School Nurse Date: ______________________



PHYSICIAN'S PLAN OF CARE
FOR ADMINISTRATION OF DIASTAT

Student's Name: ______________________ Student Number: ______________

Date of Birth: ____________ Teacher: ________________ Grade: __________

Allergies: ____

It is necessary for the above named student to have rectal Diastat _________ mgs administered in the event of seizure activity as described here:____

____

ICD 10 Code _____________

ADMINISTRATION PROTOCOL:

1. **When nurse is not present:**
   a. Trained school personnel will give rectal Diastat:
      - ☐ At onset of any seizure.
      - ☐ At _________ minutes after onset of seizure.
      - ☐ Other ____

911 will be called upon administration of Diastat by trained school personnel if nurse is not present.

2. **When nurse is present:**
   a. Give rectal Diastat:
      - ☐ At onset of any seizure.
      - ☐ At _________ minutes after onset of seizure.
      - ☐ Other ____

   b. Call 911:
      - ☐ At onset of any seizure.
      - ☐ At _________ minutes after onset of seizure.
      - ☐ At _________minutes after rectal Diastat is given, if seizure activity is still present

3. During transport:
   a. Since rectal Diastat cannot be given on a school bus or while in transit, when should 911 be called?
      - ☐ At onset of any seizure.
      - ☐ At _________ minutes after onset of seizure

STANDARDIZED PROCEDURES:

☐ I have reviewed and approve the proposed plan of care for this student.
☐ I have reviewed and approve the proposed plan of care for this student with the specific modifications I have Included below:

1. Precautions, possible side effects to observe: ______________________________
2. Recommended interventions for side effects: ______________________________
3. The above treatment(s)/intervention(s) are to be continued until ______________________.
   (Expiration Date)

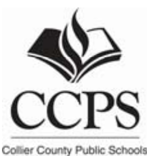
I give permission for my child's doctor to be contacted for information regarding the administration of this medication.

______________________	______________________	______________
Physician's Printed Name	Physician's Signature	Date

______________________________	______________	______________
Address	Phone Number	FAX

______________________	______________________	______________
Parent/Guardian Printed Name	Parent/Guardian Signature	Date

Reviewed by ______________________________________, School Nurse Date: ________________________



STUDENT HEALTH HISTORY- SEIZURE

Does your child take any seizure medications at home? ___ Yes ___ No If yes, please list:

Medication	Dose	How often
1.		
2.		

Administer the emergency medications listed below in the event of a seizure at school.

District Medication Authorization Forms must be completed and signed by parents and the prescribing physician and be on file at the school before any medications may be administered. Parent must bring medications to school.

Medication	Dose	Describe When to Use
1.		
2.		

EMERGENCY PLANS:

- In the event of a lockdown, medication kept in the clinic will not be available to your child. We encourage you to discuss a plan with your child's physician and the school nurse. Please note any special instructions to be included as part of your child's Emergency Action Plan below.
  ____
- In the event of an evacuation, emergency medications will be taken to the evacuation site, whenever possible.

I understand that my child's Emergency Action Plan will be shared with appropriate school staff that have a need to know about the health condition. I further understand that the school is not responsible for damage or loss of equipment utilized in providing medically prescribed treatments or procedures.

I give permission for my child's health care provider to be contacted for information regarding my child's medical condition. I have reviewed and agree with the information provided on this Health History form.

Parent/Guardian: ___________________________________ ____________________
Signature Date

Reviewed by: ___________________________________ ____________________
School Nurse Date

****

FOR SCHOOL NURSE USE ONLY

Notes: ____

____

____

Rev. 4/18

Student Name_________________ # __________