CCPS
Collier County Public Schools

PHYSICIAN'S PLAN OF CARE

FOR ADMINISTRATION OF INTRANASAL VALTOCO (Diazepam)

Student's Name: _____ Student Number: _____

Date of Birth: _____ Teacher: _____ Grade: _____

Allergies: _____

It is necessary for the above named student to have (Intranasal) Valtoco ® (Diazepam) _____ 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 Intranasal Valtoco® (diazepam):
      ☐ At onset of any seizure.
      ☐ At _____ minutes after onset of seizure.
      ☐ Other _____

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

2. **When nurse is present:**
   a. Give Intranasal Valtoco ® (Diazepam):
      ☐ 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 Valtoco ® (Diazepam) is given, if seizure activity is still present

3. During transport:
   a. Since Intranasal Valtoco ® (Diazepam) 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

Student Name: _____ Student Number: _____

Date of Birth: _____ School: _____ Teacher/Grade: _____

Doctor: _____ Doctor's Number: _____ Ride Bus: Yes__ No__

Allergies: _____

Parent/Guardian: _____ Home Phone: _____ Other Phone: _____

Parent/Guardian: _____ Home Phone: _____ Other Phone: _____

Emergency Contact: _____ Home Phone: _____ Other Phone: _____

Relationship: _____

Emergency Contact: _____ Home Phone: _____ Other Phone: _____

Relationship: _____

Year diagnosed with seizures: _____ Date of most recent seizure: _____

1. What type of seizures (what are they called) does your child experience? _____
2. What happens when your child has a seizure? _____
   _____
3. How often do seizures occur? _____
4. How long do the seizures usually last? _____
5. Any recent hospitalizations? Date(s) _____ Reason(s): _____

	Yes	No
Has a seizure ever lasted more than 5 minutes? *If yes, what treatment was needed?*		
Has Diastat ever been prescribed for your child?		
If Diastat has been prescribed, has it ever been given?		
Does your child lose bowel or bladder control during a seizure? (circle which one)		
Has your child ever turned blue or stopped breathing during a seizure? *If yes, what treatment was needed?*		
Does anything seem to trigger a seizure? ☐ Flashing lights ☐ Video games ☐ Computers ☐ Other _____		
Are there any limitations to your child's activities? ***If yes, please be specific and attach a health care provider's order for these limitations***.		

Comments or additional information: _____

*Please complete and sign reverse

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: _____

_____

_____

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Student Name_____ # _____