School: _____ **School Year:** _____

PHYSICIAN AND PARENT/GUARDIAN

AUTHORIZATION FOR DIASTAT MEDICATION ADMINISTRATION

The Board of Education of Fayette County has adopted a procedure wherein a member of the staff of the school the student is attending will administer either an injection or prescribed drug in the event of a crisis. The undersigned understands that the staff member administering the above care is not a trained health professional, but is trained by the School Nurse per state law and that this individual will undertake to do his or her best to comply with the recommended procedure as developed by the student's Physician in the case of a life-threatening emergency wherein immediate intervention is required by school personnel.

The undersigned Parent/Guardian does hereby consent to the intervention of school personnel in accordance with the instructions contained in the attached form from the student's Physician. Additionally, the undersigned agrees to hold school personnel harmless for any injuries resulting from the emergency care unless the injury was caused by school personnel's negligence.

PHYSICIAN ORDER FOR EMERGENCY ACTION PLAN

To be completed by the student's Physician and returned to School Health: Confidential FAX (859) 288-2313 or by mail: Lexington-Fayette County Health Department, School Health Division, 650 Newtown Pike, Lexington, KY 40508

STUDENT'S NAME: _____ **DOB:** _____

ALLERGIES: _____

DIAGNOSIS: _____

SIGNS AND SYMPTOMS WHEN MEDICATION IS NEEDED: _____

DRUG ORDERED, DOSAGE AND ROUTE OF ADMINISTRATION:

_____
Medication/Dose/Route

- **Per protocol, Rescue Squad (911) will be contacted if Diastat is used, unless Physician's order states otherwise.**
- **Notify Parent/Guardian or Emergency Contact.**

Comments: _____

X _____ _____
(Physician's Signature) Date

_____ _____
(Physician's Name - Printed) Telephone Number

**** PLEASE NOTE: The School Nurse is NOT always in the school building and trains non-medical staff to administer medication. See above and below.***

PARENT/GUARDIAN STATEMENT

☐ I, the undersigned Parent/Guardian of the student named above, **request that a *trained staff member administer the above medication** to the student per Physician instructions. I agree to furnish the necessary prescribed medication and agree to notify the School Nurse immediately of any changes. I understand the Fayette County Board of Education Medication Policies & Procedures (09.2241) are readily available for me to read. I sign this voluntarily and with full knowledge of its significance. I agree to pick up any unused medication within two weeks of the last day of school, or it shall be destroyed.

****Parent/Student are responsible to have medication available at school.***

Parent/Guardian Signature: _____ **Date:** ____/____/ _____

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

REVIEWED BY: _____ *RN Date:* _____