School Year: _____

PHYSICIAN AND PARENT/GUARDIAN AUTHORIZATION FOR EMERGENCY 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: _____ **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.**

VAGAL NERVE STIMULATOR PHYSICIAN AUTHORIZATION

1. Use Vagal Nerve Stimulator if seizure is longer than_____minutes by swiping the magnet from midline of the chest in a right downward motion.
2. Wait_____seconds and repeat swipe.
3. Repeat_____times._____seconds in between and observe student for further seizure activity.
4. If student continues to have a seizure longer_____minutes, **CALL 911.**

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_____, hereby request the School Nurse or designee to administer the above procedure(s) according to the Physician's instructions. I understand that a member of the school staff trained and deemed competent by the School Nurse may administer the prescribed medication in the event of a crisis. The unlicensed school personnel will do his or her best to comply with the recommended procedure as developed by the student's Physician. The undersigned agrees to hold the unlicensed staff member harmless for any injuries resulting from the emergency care unless the injury was caused by his or her negligence. I agree to furnish all equipment, supplies, medication, or other items necessary for the administration of the service/procedure and to provide replacement and maintenance as necessary. **I agree to notify the School Nurse immediately if there is any change in the student's status or Physician's orders.**

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

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

Reviewed by:_____, RN **Date:**_____/_____/_____