GREENVILLE COUNTY SCHOOLS Health Services

Authorization Form for Diastat/Valtoco/Nayzilam at School *4/2025*

This section must by completed by **Licensed Medical Provider** only: Please Print

Student's Legal Name:	**Date of Birth**:	**List Allergies :**

Diastat (rectal diazepam) Prescribed Route: Rectal **Prescribed Dose: _____mg**	**Valtoco** (intranasal diazepam) ages 2 and up Prescribed Route: Intranasal **Prescribed Dose:** ☐One 5mg nasal spray device in one nostril ☐One 10mg nasal spray device in one nostril ☐Two 7.5mg nasal spray devices, one in each nostril ☐Two 10mg nasal spray devices, one in each nostril	**Nayzilam** (intranasal midazolam) ages 12 and up Prescribed Route: Intranasal **Prescribed Dose: _____mg**

Purpose of Medication at School: Emergency Rescue Medication for Seizures

Is medication required on the daily bus route to and from school? ☐ **Yes** ☐ **No**
(all rescue medications accompany students on field trips)

Directions: ☐For seizure lasting greater than 3 minutes ☐For seizure lasting greater than 5 minutes ☐For cluster seizures (seizures that start and stop and start again) ☐ Additional instructions: _____ _____	**Date to Start** Medication**:**	**Date to Stop** Medication**:**
	Possible Side Effects: Decreased respirations, drowsiness, confusion, unsteady gait; Other:	

Licensed Medical Provider Name: (Print info or stamp is acceptable) Office Address:	**Phone:** **Fax:**
Licensed Medical Provider Signature:	**Date:**

Parents/Legal Guardian please read carefully. By signing below, I understand and agree to the following:

- I understand that all prescribed medications must be in the original container issued by the pharmacist with the most recent prescription label.
- I will notify the school when the medication/procedure is discontinued or the dosage/schedule/requirements have been changed.
- I give permission for the principal, school nurse(s), and/or health services to share this information with individuals who have responsibility for my child.
- The first dose of any new medication will be given at home so that I can monitor for adverse reactions.
- I give GCSD Health Services my permission to contact the above-named Licensed Medical Provider and prescribing pharmacy in relation to this prescription medication or procedure.
- I am responsible for replacing medication before the expiration date and replacing supplies as requested.
- I give my permission for designated GSCD staff to administer this medication/procedure to my child according to district requirements.
- A responsible adult must bring medication to the school nurse. Do not send medication with a student.
- Medication will not be accepted if the information on the authorization form does not match the prescription label.
- Medications will not be administered without this completed form including required signatures.
- The school district and its employees and agents are not liable for an injury arising from administration of procedure authorized by an ICHP (care plan) / licensed medical provider.
- The parent/guardian shall indemnify and hold harmless the district and its employees and agents against a claim arising from administration of procedure authorized by an IHP (care plan) / licensed medical provider.

Parent/Legal Guardian Printed Name: _____ Daytime Phone Number: _____

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

**This form is only valid if signed on or after June 1st for the upcoming school year. **