PARENT AGREEMENT

I UNDERSTAND THAT AFTER Diastat has been administered, ____________________ ____________ (student) will not be allowed at school for 12 hours.

I understand that after administration of Diastat outside of school, student cannot be sent to school until the school R.N. is contacted and has assessed the student and determined that the student has returned to baseline functioning.

I understand that in the event of any seizure activity requiring Diastat administration, 911 will be called and the student will only be released to his/her parent/guardian, or adult designee by parent.

I, along with the school personnel, will provide daily documentation regarding any seizure activity, changes in health or baseline functioning and any/all uses of Diastat outside of the school setting.

I give permission for information to be shared with appropriate personnel and healthcare providers, including EMS.

I have reviewed and agree with this Emergency plan. I am aware that if my child has any emergency in school and I am not available, the school or alternate will have my child transported to the Emergency room. I will be responsible for payment of the emergency care.

____________________ Principal	____________ Date	____________________ School R.N.	____________ Date
____________________ Parent	____________ Date	____________________ Teacher	____________ Date
____________________ LPN/TUP	____________ Date	____________________ Asst. Principal	____________ Date