Washoe County School District
Student Health Services
Fax: 775-353-5968

CONSENT AND REQUEST FOR ADMINISTRATION OF INTRANASAL VERSED (MIDAZOLAM) ON WCSD CAMPUSES AND DURING SCHOOL-SPONSORED ACTIVITIES

THIS ORDER EXPIRES AT THE END OF THE SCHOOL YEAR

Date _____

Student Name _____ DOB_____

School _____ School Year _____

THIS SECTION IS TO BE COMPLETED BY THE STUDENT'S HEALTH CARE PROVIDER

The following student may require administration of medication as described below:

Name of Medication: **Midazolam Solution** Route of Administration: **Intranasal**

Concentration of Vial: ○ 1 mL (5mg/ mL) ○ 2mL (10 mg/2mL)

Total dosage to be administered: _____mg/ _____mL Right nostril _____mL Left nostril _____Ml

Criteria and/or symptoms requiring medication administration: _____

Other orders/directives _____

_____

Verification that test dose has been given and student had no adverse reactions _____
health care provider initials

☑ **911/EMS will be called immediately when Intranasal Midazolam is administered.**

Health Care Provider Name (please print) _____

Phone _____ Fax _____

Health Care Provider Signature: _____ **Date:** _____

Student Name _____ DOB_____

Parent/Guardian Consent and Request for Administration of Midazolam (Nasal Versed):

The undersigned parent/guardian hereby requests the Washoe County School District ("District") to administer the above described medication to the above named student, as set forth above, and consents to such administration while the student is present on a District campus, on District transportation, and while participating in school-sponsored activities.

In addition, the undersigned parent/guardian hereby gives permission to the school nurse at the above described school to exchange confidential information, if needed, regarding the student's diagnosis, nursing management, and/or medication, with the undersigned health care provider; and further hereby agrees to assume all risk and responsibility regarding the administration of the student's medication by a District employee and to defend and indemnify and hold the Washoe County School District, the Board of Trustees of the District, and all agents, employees and contractors of the District harmless from any and all losses or liability, claims, and expenses, including any and all claims for contribution or indemnity by any party for their administration of the medication to the above named student. The undersigned parent/guardian further goes to release, discharge and waive any right, claim, action, demand, cost, expenses, or entitlement on account of or in any way growing out of or connected with any or all known or unknown causes of action resulting from the administration of the school's medication by a District employee.

The undersigned parent/guardian hereby agrees to provide the above named student with the required medication while the student is present on a WCSD campus, during WCSD transportation, and while participating in school-sponsored activities and the undersigned parent or guardian agrees to assume all responsibility for maintaining the supply of the medication and replacing such medication when its effectiveness has lapsed by reason of time. Medications that are kept in the school health office may not be sent home with students. Medications not claimed or picked up by the parent/guardian or their designee by the day following the last day of the school year will be disposed of by the school nurse or her designee.

I am in agreement with the orders set forth as stated above:

Parent/Guardian Name (please print)_____Phone: _____

Parent/Guardian Signature: _____ Date: _____

School Nurse Name/Title (please print)_____

School Nurse Signature: _____ Date: _____