LOS ANGELES UNIFIED SCHOOL DISTRICT
Medical Services Division
District Nursing Services Branch

Parent Consent and Healthcare Provider Authorization for
NASAL BENZODIAZEPINE (VALTOCO AND NAYZILAM) ADMINISTRATION
at School and School-Sponsored Events

Student:	**DOB:**	**Grade:**
School:	**Phone:**	**Fax:**

PLEASE REVIEW AND CHECK THE APPROPRIATE BOX TO INDICATE AUTHORIZATION.
NOTE: LAUSD SPECIALIZED PHYSICAL HEALTHCARE PROCEDURE FOR
NASAL BENZODIAZEPINE (VALTOCO AND NAYZILAM) ADMINISTRATION IS ATTACHED.

1. Check One:

□ I have reviewed and approved the attached standardized procedure as written
□ I have reviewed and approved the attached standardized procedure as written with the attached modifications
□ I do not approve of the standardized procedure. I have attached my alternative procedure and recommendations

2. Name of medication and dosage prescribed

Valtoco	**Nayzilam**
☐ **5 mg** = 1 spray device holding 5 mg of diazepam, in 1 blister pack ☐ **10 mg** = 1 spray device holding 10 mg of diazepam, in 1 blister pack ☐ **15 mg** = 2 spray devices, each holding 7.5 mg of diazepam, in 1 blister pack ☐ **20 mg** = 2 spray devices, each holding 10 mg of diazepam, in 1 blister pack	☐ **5 mg** = 1 spray device holding 5 mg of midazolam, in 1 blister pack

☐ **PRN needed** for (specify seizure symptoms, frequency, typeandduration) _____

3. Special Instructions: _____

Authorized Healthcare Provider Authorization for
NASAL BENZODIAZEPINE ☐VALTOCO ☐ NAYZILAM ADMINISTRATION in School Setting

My signature below provides authorization for the above written orders. I understand that all procedures will be implemented in accordance with state laws and regulations. I understand that specialized physical healthcare procedures may be performed by unlicensed designated school personnel under the training and supervision provided by the school nurse. This authorization is for a maximum of one year. If changes are indicated, I will provide the written authorization. Authorizations may be faxed.

***Authorized Healthcare Provider Name:**_____ **Signature:**_____ **Date:**_____

Phone:_____ **Address:**_____ **City**_____ **Zip** _____

***Nurse Practitioner, Nurse Midwife, Physician Assistant: Furnishing Number** _____

Parent Consent for Authorization for
NASAL BENZODIAZEPINE ☐VALTOCO ☐NAYZILAM ADMINISTRATION in School Setting

I, the undersigned, the parent/guardian of the above-named student, request that the specialized physical healthcare procedure be administered to my child in accordance with state laws and regulations. I will :

1. provide the necessary supplies and equipment;
2. notify the school nurse if there is a change in child's health status, or attending healthcare provider; and
3. notify the school nurse immediately and provide new written consent/authorization for any changes in the above authorization.
4. provide new written consent/authorization yearly.

I give consent for the school nurse to communicate with the authorized healthcare provider when necessary.

Parent/Guardian (Print Name):_____ **Signature:**_____ **Date:** _____

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

Licensed Nurse Acknowledgement of Completeness and Meets District Guidelines

Printed Name of Nurse	**Signature**	**Title (RN, LVN)**	**Date**

LOS ANGELES UNIFIED SCHOOL DISTRICT
Medical Services Division
District Nursing Services Branch

Parent Consent and Healthcare Provider Authorization for
NASAL BENZODIAZEPINE (VALTOCO AND NAYZILAM) ADMINISTRATION
at School and School-Sponsored Events

Student:	**DOB:**	**Grade:**
School:	**Phone:**	**Fax:**

PLEASE REVIEW AND CHECK THE APPROPRIATE BOX TO INDICATE AUTHORIZATION.
NOTE: LAUSD SPECIALIZED PHYSICAL HEALTHCARE PROCEDURE FOR
NASAL BENZODIAZEPINE (VALTOCO AND NAYZILAM) ADMINISTRATION IS ATTACHED.

1. Check One:

□ I have reviewed and approved the attached standardized procedure as written
□ I have reviewed and approved the attached standardized procedure as written with the attached modifications
□ I do not approve of the standardized procedure. I have attached my alternative procedure and recommendations

2. Name of medication and dosage prescribed

Valtoco	**Nayzilam**
☐ **5 mg** = 1 spray device holding 5 mg of diazepam, in 1 blister pack ☐ **10 mg** = 1 spray device holding 10 mg of diazepam, in 1 blister pack ☐ **15 mg** = 2 spray devices, each holding 7.5 mg of diazepam, in 1 blister pack ☐ **20 mg** = 2 spray devices, each holding 10 mg of diazepam, in 1 blister pack	☐ **5 mg** = 1 spray device holding 5 mg of midazolam, in 1 blister pack

☐ **PRN needed** for (specify seizure symptoms, frequency, type and duration) _____

3. Special Instructions: _____

Authorized Healthcare Provider Authorization for
NASAL BENZODIAZEPINE ☐VALTOCO ☐ NAYZILAM ADMINISTRATION in School Setting

My signature below provides authorization for the above written orders. I understand that all procedures will be implemented in accordance with state laws and regulations. I understand that specialized physical healthcare procedures may be performed by unlicensed designated school personnel under the training and supervision provided by the school nurse. This authorization is for a maximum of one year. If changes are indicated, I will provide the written authorization. Authorizations may be faxed.

***Authorized Healthcare Provider Name:**_____ **Signature:**_____ **Date:**_____

Phone:_____ **Address:**_____ **City**_____ **Zip** _____

***Nurse Practitioner, Nurse Midwife, Physician Assistant: Furnishing Number** _____

Consentimiento y Autorización de los Padres para la
ADMINISTRACIÓN de BENZODIAZEPINA NASAL ☐ VALTOCO ☐ NAYZILAM en el entorno escolar

Yo, el abajo firmante, el padre / tutor del estudiante arriba mencionado, solicito que el procedimiento especializado para el cuidado de la salud física se le administre a mi hijo / hija en acorde con las leyes y reglamentos estatales. Yo:

1. proporcionaré los suministros y equipos necesarios;
2. notificaré a la enfermera de la escuela si hay un cambio en el estado de salud del niño / niña o del proveedor de atención médica que lo atiende; y
3. notificaré a la enfermera de la escuela de inmediato y proporcionaré un nuevo consentimiento / autorización por escrito para cualquier cambio de la autorización anterior.
4. proporcionaré un nuevo consentimiento / autorización por escrito anualmente.

Doy mi consentimiento para que la enfermera de la escuela se comunique con el proveedor de atención médica autorizado cuando sea necesario.

Padre / Tutor (nombre en letra de molde):_____ **Firma:**_____ **Fecha:** _____

Teléfono del hogar:_____ **Teléfono del trabajo:**_____ **Celular:** _____

Licensed Nurse Acknowledgement of Completeness and Meets District Guidelines

Printed Name of Nurse	**Signature**	**Title (RN, LVN)**	**Date**
_____	_____	_____	_____

August 2024 Adapted from Form B, Section 3, *The Green Book: Guidelines for Specialized Physical Healthcare Physical Healthcare Procedures in School Settings (4/11)*