Physician's Order for the Administration of DIASTAT in the School Setting

Student's Name_____ **D.O.B.**_____

Medical Diagnosis_____ **Treatment: DATE**_____

• DIASTAT (diazepam rectal gel) _____mg rectally as needed for: _____seizures lasting greater than _____minutes OR for _____or more seizure in _____hours.

☐ Call 911 if DIASTAT is given ☐ Parents/caregiver should be notified immediately if DIASTAT is given

☐ **An unlicensed employee may administer this medication if trained by the nurse**

Description of the seizure for which Diastat is ordered
(Please provide a student -specific description that will permit identification of the seizure.)

1. The student has a warning before the seizure ☐ No ☐ Yes (please specify)
   _____
2. This student's seizure begins with
   [] unresponsive staring
   [] deviation of head or eyes to ☐ left ☐ right
   [] stiffening or twitching on ☐ left ☐ right ☐ both sides at the same time?
3. This student's seizure progresses with
   [] spread of stiffening and/or jerking to ☐ left ☐ right ☐ both sides of the body
   [] persisting unresponsiveness without convulsive movements
   [] cyanosis_____ ☐ other, please specify_____

Following a seizure:

[] Child should rest in nurse's office
☐ Parents/caregiver should receive a note/copy of the seizure record sent home with the child
☐ child may return to class (if DIASTAT was NOT given)

• If a seizure should occur while the child is being transported on the school bus, on a field trip or at a community based instruction site, our procedure would be to call 911.

Physician/Nurse Practitioner/Physician's Assistant Name

Printed_____ Signature_____

Address _____Phone _____

As the parent or legal guardian of the above-named child, I have read the policies pertaining to school personnel administering prescriptive medication and this is your permission to administer the above medication to my child according to the physician's order written above.

*****IT WILL BE THE PARENT/GUARDIAN'S RESPONSIBILITY TO PICK UP THE MEDICATION FROM THE CLINIC OR GIVE WRITTEN AUTHORIZATION FOR THE SCHOOL TO RELEASE THE MEDICATION. PLEASE REFER TO THE KISD MEDICATION PROCEDURE FOR ADDITIONAL INFORMATION.**

Parent's Signature:_____ Date:_____

Parent's Home Phone: _____ Business Phone: _____