Diastat/Seizure Treatment Order Form

Student Name:________________________________ **DOB:**______________
Address:____
Phone:_____________________________ **Other:**_______________________
Weight:______ **Grade:**_______ **Teacher:**____________________________
School:_________________________________ **School Year:**____________

Treatment/Orders

Diastat **(Diazepam Rectal Gel):** Dose: ____mg. as needed for seizure lasting >___minutes **OR** for _____ or more seizures in _____ hours

Other Medication(Versed, Ativan etc): ____
____

Side Effects of ordered medication:____

VNS *(Vagus Nerve Stimulator)* Magnet: _______________________________________
____

Call 911 if:

- Seizure does not stop within ________minutes of giving Diastat
- Student shows signs of respiratory distress
- Other____

Other Instructions: (bus accommodations for special education students, etc.):
____

Physician Name (*please print legibly*): ____________________________________

Phone: (   )________________________ **Fax: (   )**____________________________

Address: ____

City: ___________________________ **State:** _______________ **Zip:** ___________

Physician Signature: ____ **Date:** ___________

I am the parent/guardian of ____________________________________ and I agree to the above orders. I will notify school personnel if there is a change in these orders. I understand I am responsible for providing the school with written orders from the physician before the school will make changes in procedures or medication orders. I authorize Student Health Services personnel to discuss orders with the prescribing healthcare provider. I release the school, the school board and any Fulton County Schools or contracted employee from any liability for following these procedures or in administering Diastat to student.

Parent/Guardian Signature: ____________________________________ **Date:** ___________

This section to be completed by Special Education Nurse/Cluster Nurse/School Clinic Assistant ONLY

Does Student Ride the Bus? ______________ **Is an Aide on the bus?**_____________

Special Instructions for Transportation Personnel:___________________________________
____
____

Date Diastat Received: ______________ **Dose Ordered:** ___________ **Diastat Locked:** ___________ **Dosage Locked In:**_________

Special Ed/Cluster Nurse/Clinic Assistant Signature:_________________________________ **Date:**__________

Revised: Mar 2012