AUTHORIZATION AND PERMISSION FOR ADMINISTRATION OF
DIASTAT AND TREATMENT OF SEIZURE ACTIVITY

NAME OF STUDENT____BIRTHDATE_______________

ADDRESS____PHONE___________________

SCHOOL__________________________________GRADE________TEACHER_____________________

DIAGNOSIS____

Treatment:

- DIASTAT ® (diazepam rectal gel) _______________mg rectally prn for:
  - Seizure >_________minutes OR for ________or more seizures in ____hours.
- Other____

  ____
- Call 911 if:
  - ✓ Seizure does not stop within______minutes of giving Diastat®
  - ✓ Student does not start waking up within____minutes after seizure is over (no Diastat® given)
  - ✓ Student does not start waking up within____minutes after seizure is over (after Diastat® is given

Following a seizure:

- ☐ Child should rest in nurse's office
- ☐ Child may return to class (if Diastat® was not given)
- ☐ Parents should be notified immediately

- Expected side effects of Diastat® ____

  ____
- Action taken should the child have a bowel movement or expels the medication __________________

  ____
- Action taken if child has a respiratory infection or fever_______________________________________

  -____
- 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 side, our procedure would be to call 911. Additional comments.

  ____

  ____
- Other medications child is receiving____
- Allergies____

____

Licensed Prescriber's Signature Licensed Prescriber's Printed Name

____

Address Phone Date

Parent/Guardian Permission

- I hereby request and give my permission for the above named school to administer the medication and give the treatment prescribed on this form to my child.

____

Parent/guardian Signature Home phone Work phone Emergency phone Date