

ORDER FOR THE ADMINISTRATION OF DIASTAT IN THE SCHOOL SETTING

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

Student #: _____ **Medical Diagnosis:** _____ **ICD-9 Code:** _____

Treatment:

* DIASTAT® (diazepam rectal gel) _____ mg rectally as needed for: _____
seizures lasting greater than _____ minutes OR for _____ or more seizures in _____ hours.

* Use VNS (vagal nerve stimulator) magnet _____

*Other _____

***Call 911 if DIASTAT is given**

*** Parents / caregiver should be notified immediately**

***Let EMS Personnel know if:**

- Seizure does not stop by itself or with VNS within _____ minutes.
- Seizure does not stop within _____ minutes OF GIVING diastat or if 1st dose DIASTAT ever received.
- Child does not start waking up within _____ minutes after seizure is over (no DIASTAT given).
- Child does not start waking up within _____ minutes after seizure is over (after DIASTAT given).

Following a seizure: Child should rest in nurse's office Child may return to class (if DIASTAT was NOT given)

Parents / caregiver should receive a note / copy of the seizure record sent home with the child

* What side effects can be expected after the admisistration of DIASTAT?

* What was the child's response to the first dose of DIASTAT?

* If the child has a cold, respiratory infection or fever, should the DIASTAT be 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. Any additional comments?

Physican / Nurse Practitioner / Physician's Assistant Name (Printed)

Signature _____ Date _____

Address _____ Phone _____

Parent / Guardian Signature _____ Date _____