Student Health Services

Diastat Administration

Student's Name: _____Weight: _____lbs DOB: _____

Grade: _____ Teacher: _____ School:_____

Diagnosis:_____

Diastat Rectal Gel Dosage: _____Other Medications: _____
(See Authorization for Medication Forms)

CHECK SPECIFIC TREATMENT ORDERS BELOW:

1. INDICATION FOR THE ADMINISTRATION OF DIASTAT:

- ❑ **Generalized seizure of 5 minutes or greater duration**
- ❑ **Two or more consecutive seizures (without a period of consciousness between) that last 5 minutes or more**
- ❑ **Other_____**

2. CONTRAINDICATIONS/SIDE EFFECTS: (Please Print): _____

_____

_____

3. FREQUENCY OF ADMINISTRATION OF DIASTAT:

For the above student, when indicated as marked above, Diastat:

- ❑ **May only be administered once every five (5) days per the manufacturer's recommendation.**
- ❑ **A second dose may be administered 4 to 12 hours after the first dose.**
- ❑ **May be administered _____ times every _____(hours/days)**
- ❑ **Call 911 if Diastat given.**

I am the parent/guardian of _____and request that Diastat be administered during school hours.

FCBOE School employees will not assume any liability for supervising or assisting in Diastat administration in the school setting. Completion of this Diastat Administration Form authorizes Student Health Services to discuss the Diastat Administration with the appropriate school staff and prescribing healthcare provider via email, fax, verbal, or written communication with the purpose of providing a safe environment for your child.

Physician/Healthcare Provider: _____Date: _____

Physician Name (Print): _____Phone Number: _____

Parent Signature: _____Date: _____

To be completed by Clinic Assistant/Cluster Nurse/Special Education Nurse only:

Received Date: _____ Medication: _____

Number of Doses: _____ Expiration Date: _____ Diastat Locked_____