Medication/Treatment Authorization Form - Diastat

Name of Student: _____ Date of Birth:_____
School: _____ Grade: _____

It is necessary for this student to be given Diastat_____mgs. in the event of seizure activity as described:

_____
_____

Patient's DIASTAT® dosage is: _____mg
Patient's resting breathing rate _____
Patient's current weight _____ Confirm current weight is still the same as when DIASTAT® was prescribed ☐

1. Give Diastat: ☐ At onset of seizure ☐ _____ minutes after onset of seizure.

2. When at school or on a field trip with trained school personnel **Call 911**:
   - ☐ onset of seizure
   - ☐ _____minutes into seizure
   - ☐ _____minutes after Diastat is given, if seizure activity is still present

3. Transportation Orders: Since Diastat is not given on the school bus, **911 will be called** at onset of seizure.

***4. Diastat will not be given for the FIRST time in the school setting in accordance with CCPS District Policy 5330; Physician order must be written to include if Diastat is to be stored at school site for EMS administration only**

Precautions, possible side effects for recommended intervention:

_____
_____

Print Name of Licensed Health Care Provider _____

Signature of Licensed Health Care Provider _____Date: _____
Address:_____City:_____Zip Code: _____
Telephone Number: _____Fax Number: _____

To be completed by PARENT/GUARDIAN: Please read and sign the following:

I hereby grant permission to the principal or his/her designee of _____ School to assist in the administration of the prescribed medication and/or treatment to my child while in school and away from school while participating in official school activities (F.S. 1006.062). **It is my responsibility to notify the school if and when these orders change**. I understand the law provides that there shall be no liability for civil damages as a result of the administration of such medication and/or treatment where the person administering such medication and/or treatment acts as an ordinarily reasonably prudent person would under the same or similar circumstances.

Parent's Signature: _____ Date: _____

Please **print** Parent's name:_____

Does this medication need to be provided during field trips? ____Yes ____ No