

**PHYSICIAN'S ORDER FOR THE ADMINISTRATION OF DIASTAT IN THE SCHOOL SETTING**  
(Form to be completed by Student's Physician)

<b>STUDENT'S NAME:</b>	PHOTO HERE
<b>DATE OF BIRTH:</b>	
<b>SEIZURE INFORMATION</b>	
<b>Seizure Type:</b>	
<b>Frequency of Seizures:</b>	
<b>Seizure Triggers:</b>	
<b>Description of Seizures:</b>	

**DIASTAT ORDERS:**

- DIASTAT AcuDial (diazepam rectal gel): \_\_\_\_\_mg, rectal as needed for seizure lasting greater than \_\_\_\_\_ minutes OR for clusters such as \_\_\_\_\_ or more seizures in \_\_\_\_\_ minutes/hours (please circle).
- If Seizure continues longer than \_\_\_\_\_ minutes after first dose is given:  
 Call 9-1-1       Other: \_\_\_\_\_
- Additional Treatment Information: \_\_\_\_\_
- What action should be taken if the child has a bowel movement or expels the medication?  
 • \_\_\_\_\_
- If the child has breathing difficulties (i.e. known asthma), a respiratory infection or fever, should the DIASTAT be given?  
 Yes       No \_\_\_\_\_
- Possible adverse effects and action to be taken: \_\_\_\_\_
- Call 9-1-1       Other: \_\_\_\_\_
- If licensed nurse not available when DIASTAT is given, staff will call 911. Parents/Caregiver will be notified immediately.
- **If a seizure should occur while the child is being transported on the school bus, the procedure will be to call 911.**

I have reviewed and approved the attached RCSD protocol as written and I understand the the service may be performed by trained non-medical school personnel.

I have reviewed and approved the attached RCSD protocol with the attached modifications and I understand the service may be performed by trained non-medical school personnel.

I do not approve RCSD's protocol and, therefore, have attached my alternative written recommendations.

My signature below provides the authorization for the above written orders. I understand that assistance with medications will be implemented in accordance with California state laws and regulations. I understand that specialized physical health care services and medication assistance may be performed by unlicensed, designated school personnel after the training by the school nurse. If changes are indicated, I will provide new written authorization (may be faxed). Medication is authorized through July 31 of each school year unless otherwise indicated.

**Alternate medication authorization expiration date:** \_\_\_\_\_

\_\_\_\_\_      \_\_\_\_\_  
 PHYSICIAN'S NAME (please print)      PHYSICIAN'S SIGNATURE

\_\_\_\_\_      \_\_\_\_\_      \_\_\_\_\_  
 ADDRESS      PHONE      FAX