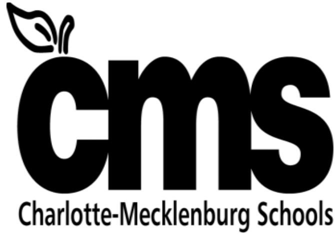

Mecklenburg County Health Dept

SCHOOL HEALTH SERVICES
A Partnership for Serving Children

Order: Diastat in School

Student's Name: ____________________________________ DOB: ______________________
Student's Address: ____
Student's Phone #: __________________________ Student's I.D: _________________________
Mother's Name: ___________________ Phone: Work ________________Cell ________________
Father's Name: ____________________ Phone: Work ________________Cell ________________
Preferred Hospital: ____
School: _______________________________ Teacher/Grade/Homeroom: ___________________

Student's Diagnosis: ____

Please have the student's Health Care Provider complete the following information:

1. Observe seizure activity and time the seizure.
2. If seizure is longer than _____ minutes in duration give Diastat _____ mg. rectally as ordered following proper procedure.
3. Monitor vital signs.
4. Assess student for specific behaviors and movements during the seizure and complete the seizure flow sheet. Remain with the student.
5. Notify parent/guardian. Student must be picked up from school.
6. Observe for decreased breathing or heart rate, change in color, head injury at time of seizure, duration and number of seizures.
7. Call 911 if :
8. Document medication given on medication record.
9. Other:

Duration of order: School Year_________________

Health Care Provider ________________________ Phone # ________________FAX #______________
Address:____
Health Care Provider's Signature: ______________________________________
Date: _______________
(Please sign here to authorize this order and return to the School Health Program, MCHD, 3205 Freedom Drive, Suite 8500-Building K Charlotte, N.C. 28202 Fax: 704-432-2079 Attn: School Health.)

I have reviewed this order and give my permission for the School Health Nurse to train school personnel to follow this order.
Parent /Guardian Signature____**Date**______________
I have provided training and instruction regarding this order to: __________________________________
(Signatures of personnel trained)
____,____
____

School Health Nurse Signature______________________________________ **Date**______________