Every child. Every day.
Mooresville
GRADED SCHOOL DISTRICT

DIASTAT ORDER FOR SEIZURE ACTIVITY

NAME: _____ **Date of Birth:** _____

School: _____ **Grade:** _____ **Homeroom Teacher:** _____

Contact Information:
Parent/Guardian: _____ **Telephone # (w)** _____
Address: _____ **Telephone # (h)** _____
Emergency Contact: _____ **Telephone #** _____

Physician Treating Student for Seizures: _____ **Telephone #** _____
Other Physician: _____

Doctor's/Healthcare Provider's Order/Instructions for the School Nurse: Train and instruct school personnel to:

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

Duration of the Diastat Order: School Year _____.

Doctor/Healthcare Provider Name: _____

Telephone Number: _____ **Fax Number:** _____

Address: _____

_____ _____
Signature Authorizing Order **Date**

Parent: I, _____ **have reviewed this order on** _____ **and give my permission for the school nurse to train school personnel to follow this order.**

Parent Signature: _____ **Date:** _____

Nurse: I, _____ **the school nurse who serves** _____ **School have provided training and instruction regarding this order to the following school personnel:**

1. _____
2. _____
3. _____

School Nurse Signature: _____ **Date:** _____