FRIENDSWOOD INDEPENDENT SCHOOL DISTRICT
HEALTH SERVICES

Diazepam Rectal Gel (Diastat) Orders

Student's Name _____

Grade _____ School year _____ Teacher _____

Procedure for Administration of Diazepam Rectal Gel (Diastat):

1. Dosage:_____

2. Indications for treatment including length of time seizure should last before treatment begins:_____
   _____

3. Side effects expected after the administration of medication: _____
   _____

4. Action to be taken if child has bowel movement or expels medication:_____
   _____

5. Protocol is to call 911 after administering Diazepam Rectal Gel unless specifically ordered otherwise (and always after initial dose of this drug.) ***__Please explain in detail any circumstances in which it is not necessary to call 911:__**
   _____
   _____
   _____

6. **PLEASE NOTE: If prolonged seizure occurs at any time when a school nurse is not available, 911 will be called!**

Printed name of physician:_____

Physician's signature: _____

Physician's phone number: _____ Fax:_____

Date: _____

I request that Diazepam Rectal Gel (Diastat) be administered to my child according to the signed protocol from my child's physician.

Parent's Signature _____ Date: _____

Emergency phone numbers _____