Hitchcock I.S.D.
Health Services

Diastat Order

Student's Name:________________________________ DOB__________________________
Student's Address____
Student's Phone #:___________________________ Student's I.D.: _______________________
Mother's
Name:______________________________Work_______________Cell___________________
Father's Name________________________ Work_______________ Cell__________________
Emergency Contact___________________________________
Phone:____________________________
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. Assess student for specific behaviors and movements during the seizure and 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, duration and number of seizures.
6. Call 911 if :
7. Document medication given on medication record.
8. Other:

Duration Of the 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 Hitchcock I.S.D. School Health Program at 7013 Stewart Rd. Hitchcock, TX 77563 or fax 409-986-5563, phone 409-986-5561
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

____, _____________________________________(
Signatures of personnel trained Signatures of personnel trained

School Health Nurse Signature_____________________________________
Date______________