



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 _____