The School District of Lee County
Health Services

THE SCHOOL DISTRICT OF LEE COUNTY
HEALTH SERVICES

PHYSICIAN'S ORDER AND PARENT CONSENT FOR PROCEDURE RELATED TO INSERTION OF DIASTAT

School: _____ Date: _____

Student's name: _____ Student's D.O.B. _____

It is necessary for my patient to have Diastat in the event of seizure activity during school hours.

1. Give Diastat_____mgs at onset of seizure : ◯ Yes ◯ No or if no then give at _____ minutes after onset of Seizure
2. When at school or on a field trip with trained school personnel:

   Call 911:at onset of seizure ◯ Yes ◯ No If no then call at_____minute after onset of seizure or at____minutes after Diastat is given, if seizure activity still present

   *** If 1st time administration of Diastat, 911 will be called when Diastat is given.**
3. Has the student ever received Diastat: ◯ Yes ◯ No
4. Transportation Orders: Since Diastat is not given on the school bus,

   911 should be called: at onset of seizure: ◯ Yes ◯ No If no, then call at ____ minutes into seizure.
5. Precautions, possible side effects for recommended intervention. _____
6. The School Nurse is authorized to instruct non-medical, trained personnel in the administration of this procedure.
7. Treatment/Procedure is to be continued for the current school year including ESY _____

Print Physician's name: _____ Physician's signature: _____

Physician's Phone: _____ Physician's Fax: _____

Parent/Guardian Consent

My permission is granted for personnel of this school and any school within the District, to which my child may transfer during the school year, including summer school, to carry out the procedure identified above.

I specifically request that this treatment/procedure be administered by members of the school staff who have been trained by the school nurse. I understand that these persons may not be medical personnel. I release the School Board and any of its employees from all claims, demands, damages, actions, causes of action or suits at law or in equity, of whatsoever nature against the School Board and any of its employees for administering said treatment/procedure.

I also understand that I will be required to provide the Diastat and any equipment necessary to administer this medication. In the event that a trained person is not available to perform the procedure, the protocol for 911 will be followed and parent will be notified.

Parent/Guardian name: _____ signature: _____ Date: _____

Phone: _____ School Nurse signature: _____