Okeechobee County School Health Services

PHYSICIAN AUTHORIZATION FORM

DIASTAT (DIAZEPAM RECTAL GEL)

Student Name: _____ **DOB**: _____ **Date**: _____

Part I: To be completed by the physician's office

The above named student has a history of seizures Type:_____

Description of Seizures:

_____

_____

And requires the following emergency medication be available and ready for use at the school:

Emergency treatment (please check ALL that apply)

Diastat (diazepam rectal gel) _____ mg rectally:

☐ as soon as seizure begins

OR

☐ for a seizure lasting longer than _____ minutes

AND/OR

☐ if _____ or more seizure happen within one hour

Please choose one:

☐ The Diastat medication must be in the possession of a trained adult who will be with the child throughout the school day, including the school bus ride. This means the student will ride a specialized bus that includes a bus aide who will be trained to administer the emergency medication.

☐ The Diastat medication must be in the possession of a trained adult who will be with the child throughout the school day but **does not** need to be available during the school bus ride. This means there **will not** be an adult on the school bus who is trained to give the emergency medication.

☐ The Diastat medication will be locked in the school clinic and will not be available during the school bus ride.

Additional comments or instructions: _____

_____

Physician's name (print): _____ Physician Signature: _____

Date: _____ Phone #: _____

Part II: To be signed by parent and school nurse

Parent Signature: _____ Date:_____

School Nurse Signature: _____ Date:_____

For School Nurse/MD Office Use: Return to _____*at School*_____

Fax number _____