Charlotte-Mecklenburg Schools

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, Hal Marshal Annex, 618 North College Street, 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**_____