PRINCE GEORGE'S COUNTY PUBLIC SCHOOLS

Prescriber's Medication Order Form

Emergency Medication-DIASTAT-For Management of Seizures

This order is valid ONLY for school year (current) ________________________ including the ESY/summer session.

Name of School: ____

FOR COMPLETION BY PARENT(S)/GUARDIAN(S):

Full Name of Student: ______________________________________ Date of Birth: _____________ Grade: ________

Known Allergies: ☐ None ☐ Specify: ____

- **I** hereby authorize the medication described below to be administered as directed by my child's health care prescriber.
- **I** understand that the prescriber will be called if a question arises about my child's medication as allowed by HIPAA.
- **I** understand that ALL medications must be labeled with the name of the medication, name of the student, name of the prescriber, date, and directions for administration and prescription medication(s) must be labeled by a registered pharmacist.
- **I** understand that I must supply the school with the equipment/supplies needed to administer the medication.
- **I** understand that at the end of the school year, an adult must pick up the medication, otherwise it will be discarded.
- **I** understand **911 will be called immediately**

Parent/Guardian Signature: ____ Date: ________________

Home phone #: ______________________Cell phone #: ______________________Work phone #: ______________________

FOR COMPLETION BY PRESCRIBER

Medication Name: **DIASTAT (Diazepam rectal gel)** Dose: ____________ mg Route: **Rectal**

Reason for: **Medication Control of Seizures** Seizure type: ____

Medication is to be given after ________ minutes of seizure activity

(Please Note: **911 WILL BE CALLED IMMEDIATELY AFTER ADMINISTRATION**)

Side Effects: ____

Date medication began: ___________________________ Date medication discontinued: ___________________________

Month/ Day/ Year Month/ Day/ Year

Prescriber's Signature: ____ Date: ______________________

(Original Signature or signature stamp only)

Prescriber's Name/Title: ______________________________________ Address:

____

(Please print or type)

Telephone: _____________________ FAX: ______________________ _________________________________

Order reviewed by RN/LPN: ____ Date: _____________________