Douglas County School System

P.O. Box 1077 ~ Douglasville, GA 30133 ~ 770-651-2000 ~ www.douglas.k12.ga.us

Mr. Trent North, Superintendent

DOCTOR'S ORDERS FOR EMERGENCY SEIZURE MEDICATION
(Including but not limited to Diazepam, Diastat, Midazolam and Versed)

Student's Name_____________________________ Weight _______kg _________lbs

Birth Date ____________ Grade__________ School ___________________________

Diagnosis ____

Medication: **Diastat/Diazapam Rectal Gel** **Dose: ____________ Route: Rectally**

Versed/Midazolam Intranasal Spray **Dose: ____________ Route: Intranasal**

Other: _______________________ **Dose: ____________ Route: ________**

Physician Section:

<u>CHECK YOUR SPECIFIC TREATMENT ORDERS BELOW:</u>

1. **INDICATION FOR THE ADMINISTRATION OF** Emergency Seizure Medication (Diazepam, Diastat, Midazolam or Versed)
   - ☐ **Generalized Tonic Clonic seizure of 5 minutes or greater duration**
   - ☐ **Two or more generalized Tonic clonic seizures without a period of consciousness between them**
   - ☐ **Other:**
     Describe:____
     ____

Name of Physician (Please Print)________________________ Date:_______________________________

Phone Number:___________________________Physician Signature________________________________

Parent/Guardian's Section

I hereby request and give my permission for school district personnel to administer the prescribed emergency seizure medication to my child in accordance with the specific written instructions of our medical provider. I do hereby release all school employees and the Board of Education from liability for damages, illness or injury resulting from either performing or not performing any assistance requested.

I am responsible for the delivery of the medication to the school clinic and will notify the school immediately if the doctor changes the dosage or administration instructions.
The medication I have brought to school expires on___________________ and will be destroyed if not picked up by the last student day of the school year provided.

I understand this medication may be administered to my child by a medically unlicensed staff member at my child's school who has completed required training conducted by a licensed nurse or physician.

911 will be notified whenever emergency seizure medication is given.

Name of Parent/Guardian (Please print)___________________________________

Signature: ____ Date:_______________________

Form to be completed by medical provider