PRINCE GEORGE'S COUNTY PUBLIC SCHOOLS
PRESCRIPTION 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: _____