EDINBURG CONSOLIDATED INDEPENDENT SCHOOL DISTRICT

HEALTH SERVICES DEPARTMENT

ADMINISTRATION OF DIAZEPAM RECTAL GEL MEDICATION

Name of Student _____ Date _____

Grade _____ Campus _____ ID# _____

Physician Order:

The above named student has a **Seizure Disorder**

Administer: Diazepam Rectal Gel _____ mg rectally, PRN for: (check all that apply)

- ☐ Seizures lasting more than ____ minutes
- ☐ When the following circumstances / signs & symptoms occur:

_____

_____

Call 911 if:

- ☑ Seizure lasts longer than 5 minutes or if it occurs in water or if the seizure stops and then resumes. Also if the student is pregnant or a known diabetic or if the student sustained an injury or does not regain consciousness after the seizure.
- ☐ Other _____

_____

After administering Diazepam Rectal Gel, allow student to rest in the nurse's office and:

- ☐ Have parent / guardian pick student up
- ☐ Other _____

_____

Physician _____ Date _____

PARENT / GUARDIAN STATEMENT

As parent / guardian of _____, I give school personnel permission to administer Diazepam Rectal Gel to my son/daughter as prescribed by his/her physician above or attached order.

Parent / Guardian _____ Date _____