HARRISON COUNTY SCHOOL DISTRICT
Medical Orders for Special Health Care Procedures
(Administration of Diastat Rectal Gel)
Valid for One School Year

STUDENT NAME: _____ DATE OF BIRTH: _____

SCHOOL NAME: _____ GRADE: _____

Dear Medical Provider:
A parent/guardian request has been made for the administration of Diastat Rectal Gel for the above named student. Medical authorization is needed before the procedure can be carried out at school. Please complete the designated section below and return it to the parent/guardian or school nurse listed below.

SECTION TO BE COMPLETED BY: MEDICAL PROVIDER

1) Physical condition(s) for which the specialized procedure is to be done:

2) Name and description of specialized procedure:

Administration of Diastat Rectal Gel _____ mg for seizure lasting _____ minutes.

3) Precautions, potential complications, and needed actions:

4) Person(s) authorized to perform procedure:

☒ Registered (School) Nurse ☒ Trained School Staff ☐ Student

5) Medical Provider Signature:

_____ _____
Signature Date

SECTION TO BE COMPLETED BY: PARENT OR LEGAL GUARDIAN & SCHOOL NURSE

I request that the following specialized physical health care service be administered to my child:
Administration of Diastat Rectal Gel in the event of a seizure.

I ask that assistance by the school nurse or trained school staff be provided to my child in taking the indicated medication. Authorization is hereby granted to release this information to appropriate school personnel. I give my permission for the prescribing health care provider named above to release medical information pertaining to this medication to the Harrison County School District.

_____ _____
Parent/Legal Guardian Signature Date

_____ _____
School Nurse Signature Date

PLEASE RETURN THIS FORM TO THE SCHOOL NURSE AT THE FAX NUMBER LISTED BELOW

SCHOOL NAME: _____ FAX NUMBER: _____

SCHOOL NURSE: _____ PHONE NUMBER: _____