Cobb County School District Form JGCD-11 *Empowering Dreams for the Future*



**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: |  |

**CHECK YOUR SPECIFIC TREATMENT ORDERS BELOW:**

1. **INDICATION FOR THE ADMINISTRATION OF** Emergency Seizure Medication (including, but not limited to Diazepam, Diastat, Midazolam, and Versed):

|  |  |
| --- | --- |
| Generalized seizure of 5 minutes or greater duration | |
| Two or more consecutive seizures (without a period of consciousness between) that last 5 minutes or  more | |
| Other: |  |

1. **CONTRAINDICATION(S) (Please Print):**

|  |
| --- |
|  |

1. **FREQUENCY OF ADMINISTRATION OF** Emergency Seizure Medication (including, but not limited to Diazepam, Diastat, Midazolam, and Versed)**:** In accordance with manufacturer’s FDA approved recommendation, the Cobb County School District will not administer Diastat Rectal Gel more than once in a five (5) day period unless the student’s physician orders otherwise below.
2. **For this student, when indicated as marked above,** Emergency Seizure Medication (including, but not limited to Diazepam, Diastat, Midazolam, and Versed):

**May only be administered once every five (5) days per the manufacturer’s recommendation.**

**A second dose may be administered 4 to 12 hours after the first dose.**

**May be administered** **times every** **(specify a number of hours OR days).**

|  |  |
| --- | --- |
| Name of Physician (Please Print): |  |

|  |  |
| --- | --- |
| Address: |  |

|  |  |
| --- | --- |
| Phone: |  |

|  |  |  |
| --- | --- | --- |
| Physician Signature: |  | and |

|  |  |  |  |
| --- | --- | --- | --- |
| Georgia Board Certification Number: |  | Date**\***: |  |

**\*This order will be valid for one calendar year from the date of the physician’s signature.**