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):

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| [ ]  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):**

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|       |

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).**

|  |  |
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| 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.**