

**HILLSBOROUGH COUNTY PUBLIC SCHOOLS
Student Support Services / School Health Services**

DATE:	RETURN TO:
TO:	SCHOOL:
	ADDRESS:
	TELEPHONE:
NAME:	FAX:
D.O.B:	
PARENT / GUARDIAN:	

This form is being presented to you in order to request:

- Physicians Orders for Medical Procedures** (*Please specify under response*)
 Medical Information: past () / current (); an authorization signed by parent is attached.
 Exchange information

COMMENTS (to be completed by sender with assistance from Parent / Guardian)

RECTAL VALIUM PHYSICIAN ORDERS

Patient's dosage is: _____ mg

- Administer Rectal Valium: a) at onset of seizure _____ b) as soon as _____
c) 3 minutes from onset of seizure _____ d) 5 minutes from onset of seizure _____
- List Type of Seizure(s) that require the administration of this medication: Type: _____
- The Rectal Valium will be kept at school in the clinic.
How long should the student be monitored after the administration of Rectal Valium? _____
How soon should the seizures stop or decrease in frequency after administering Rectal Valium? _____
If the seizures do not stop after administering the Rectal Valium, what should be done? _____

- Parent will be called after medication is administered to take student home. 911 will be called if student develops respiratory difficulties, apnea or status epilepticus.
- Rectal Valium will not be administered by School Bus Personnel; however, standard seizure protocol will be followed by Bus Personnel.

Response Requested Yes No _____ **Signature:** _____

Response/Order (To be completed by MD)

This student will be attending school and we are requesting Physician's Orders to do the following procedure at school. Please read the statements above and below and add or delete to the statements as needed. Thank You.

Rectal Valium to be administered by School Health Personnel or Trained Staff in the event of the above described Seizure Activity.

Physician's Signature: _____ **Date:** _____