Notification:
I wish to be notified if Diastat is administered _____ No_____ Yes
I wish to be notified if the child is brought by ambulance to the hospital ____ No____ Yes

Student Information:

B/P_____ **P** _____ **R** _____

Other medical conditions: _____

_____

Other medications taken by student: _____

_____

Student Allergies: _____

Contraindications to this medication or potential adverse effects specific to this student:_____

_____

_____

Other Comments: _____

_____

Any future changes in directions for this medication requires new physician's orders. All medication orders must be renewed each year. *

Physician's Name (Printed) _____ Address: _____

Physician's Signature:_____ Office Phone: _____

State License Number: _____ Office Fax: _____

Emergency Phone: _____ Date: _____