Clarksville-Montgomery County School System
HEALTH SERVICES
REPORT OF ADMINSTRATION OF DIASTAT

Date: _____ School: _____

Student's Name: _____ D.O.B.: _____

Time seizure began: _____ Time Diastat given: _____

Observations made, if any: _____
_____

Seizure description: _____
_____
_____

Change in respiratory rate: _____

Change in color: _____

Side effects of medication noted: _____
_____

Action taken: _____
_____

Time seizure ended (if ended while in care of school staff): _____

Where was used material disposed of? _____

Witness of disposal: _____

Time 911 called: _____ Time 911 arrived: _____

Time parents notified? _____ Response: _____
_____
_____

_____
Signature of CMCSS Employee completing form

_____ _____
Time Date