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