CAMP CHRISTOPHER
AUTHORIZATION AND PERMISSION FOR ADMINISTRATION
OF DIASTAT AND TREATMENT OF SEIZURE ACTIVITY

CAMPER NAME: ______________________________________ BIRTHDATE: ___________________

ADDRESS: ____ PHONE: ______________________

ALLERGIC TO: ____

- ☐ No known allergies to medication

NAME OF MEDICATION: ____

Dose: _________________________
Route:
- ☐ Rectal
- ☐ Other: _________________

TIME(S) TO BE GIVEN: For treatment of __________________ type of seizure/seizures lasting longer than _____ minutes

- ☐ Reason Given: ________________________________
- ☐ Begin Date (an actual date must be filled in): _________________
- ☐ End Date (an actual date must be filled in): _________________

SPECIAL INSTRUCTIONS: (i.e. reactions to report to physician, camper can administer own Insulin, etc…)

- ☐ Dose is to be repeated within _____ minutes if seizure is not resolved
- ☐ Call 911 if Diastat delivery does not resolve seizure within _____ minutes
- ☐ Dose is NOT to be repeated
- ☐ Other: ____

I, the undersigned, am the parent/guardian of the above named camper and hereby attest that the above information is accurate and will notify the camp healthcare staff if the above information is no longer correct.

Parent/ Guardian Signature: _______________________________ Date: ________________

Emergency Contact Name: ________________________________

Relation: ______________________ Phone: ___________________