

Protocol Form

for the administration of
Rectal Diazepam or Midazolam



Please complete this form, and return with your Doctor's / the guests Doctor's authorisation within six weeks of the date of the booking to:

Guests Booking's Administrator, Break, Davison House, 1 Montague Road, Sheringham, Norfolk NR26 8WN.

GUEST'S PERSONAL DETAILS

Surname _____ First name(s) _____

Home address _____

_____ Postcode _____

Date of Birth _____

Description of seizures requiring medication _____

What Medication is to be administered? _____

Additional Information that is relevant to this protocol _____

DOCTOR'S CONFIRMATION

Doctor's Full Name _____

Practice address _____

Telephone Number _____

Signature _____ Date _____

Guest / Parent / Carers' Full Name _____

Signature _____ Date _____