SEIZURE Medication/Management Orders (SMMO)

Utah Department of Health/Utah State Board of Education
In Accordance with UCA 53A-11-603.5

Pediatric Neurology Clinic PCH 801-213-3599 Fax: 801-587-7539	**Other provider**

STUDENT INFORMATION

Student:	**DOB:**	**School:**	**Grade:**
Parent:	**Phone:**		**Email:**
Physician:	**Phone:**		**Fax:**
School Nurse:	**School Phone:**		**Fax:**

SEIZURE INFORMATION

Seizure Type	Length	Frequency	Description

- If Seizures are full body tonic-clonic, rescue medication may be administered by a trained volunteer.
  Seizures other than tonic-clonic, rescue medication can only be given by an RN, Parent or EMS.
- Student has received a first dose of this medication in a non-medically-supervised setting without a complication? ☐ **Yes** ☐ **No**
  If No, medication cannot be given by a trained volunteer can only be given by an RN, Parent, or EMS.
- Student has previously ceased having a full body prolonged or convulsive seizure as a result of receiving this medication? ☐ **Yes** ☐ **No**
  If No, medication cannot be given by a trained volunteer can only be given by an RN, Parent, or EMS.

Parent: complete the above section, read and sign below, obtain signature from Health Care Provider and return to school nurse.

As parent/guardian of the above named student, I give permission for my child's healthcare provider to share information with the school nurse for the completion of this order. I understand the information contained in this order will be shared with school staff on a need-to-know basis. It is the responsibility of the parent/guardian to notify the School Nurse of any change in the student's health status, care or medication order. If medication is ordered I authorize school staff to administer medication described below to my child. If prescription is changed a new SMMO must be completed before the school staff can administer the medication. Parents/Guardian are responsible for maintaining necessary supplies, medications and equipment.

Parent Signature:_____ Date:_____

EMERGENCY SEIZURE RESCUE MEDICATION

To Be Completed by Prescriber - In accordance with these orders, an Individualized Health Care Plan (IHP) must be developed by the School Nurse and parent to be shared with appropriate school personnel, *and cannot be shared with any individual outside of those public education employees without parental consent.* As the student's LIP I confirm that the student has a diagnosis of seizures.

Give Emergency Medication IF:	Medication	Dose	Route	Call
• If seizure lasts _____ minutes or greater • If 2 or more consecutive seizures with or without a period of consciousness (in ____ minutes) • Other_____	☐ Midazolam (Versed) (Dose must be provided in 2 syringes) ☐ Diazepam (Diastat) ☐ Other _____	_____ mg _____ ml	☐ Nasal ☐ Rectal ☐ Other	**ALWAYS call 911, parent and School Nurse**

ROUTINE SCHOOL MEDICATION

Name of Medication	Indication	Dosage	Route	Time	Parent must transport all medication to school
1.					
2.					

☐ This medication is necessary during the school day. Trained personnel should and will be allowed to administer this medication.

Common potential side effects: respiratory depression, nasal irritation, memory loss, drowsiness, fatigue, other:_____

Additional instructions for administration:

SPECIAL CONSIDERATIONS

Does the student have a Vagus Nerve Stimulator? ☐ Yes ☐ No If YES, describe magnet use:

Special Considerations and Precautions (regarding school activities, sports, trips, helmet, height restriction, etc)

PRESCRIBER SIGNATURE

This order can only be signed by an MD/DO; Nurse Practitioner, Certified Physician's Assistant or a provider with prescriptive practice.

Prescriber Name:_____ **Phone:**_____

Prescriber Signature: _____ Date:_____

School Nurse Signature:_____ Date_____