Seizure – medication management order Seizure rescue medication authorization (In accordance with UCA 53G-9-505) Utah Department of Health & Human Services/ Utah State Board of Education	Healthcare provider: School year:	Picture

Student information

Student name:	Date of birth:	Grade:	School:
Parent name:	Phone:		Email:
Physician name:	Phone:		Fax:
School nurse:	School phone:		Fax:

Seizure information

Seizure type/description	Length	Frequency

Parent to complete (must be completed before this form is sent to the student's healthcare provider)

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.

☐ Yes ☐ No I certify that I have previously administered the seizure rescue medication in a non medically-supervised setting without complication.

☐ Yes ☐ No I certify my child has previously stopped having a full body prolonged or convulsive seizure activity as a result of receiving this medication.

Please note, that if the answer is "no" to either question above, a student's medication can only be given by an RN, parent, or EMS.

☐ Yes ☐ No I certify my student's healthcare provider has prescribed a seizure rescue medication for him/her.

☐ Yes ☐ No I give permission for the school identify and train school employees who are willing to volunteer to receive training to administer a seizure rescue medication to my child.

☐ Yes ☐ No I give permission for a trained school employee volunteer to administer the seizure rescue medication to my child.

Parent signature:	Date:

As parent/guardian of the above-named student, I give permission for my student'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 my responsibility to notify the school nurse of any change in my student's health status, care, or medication order. I authorize school staff to administer medication described below to my student. If my student's prescription is changed, a new form must be completed before the school staff can administer the medication. I am responsible for maintaining necessary supplies, medications, and equipment.

Parent signature:	Date:

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Seizure medication management order

Student name:	Date of birth:	School year:

Prescriber to complete

Emergency seizure rescue medication

In accordance with these orders, an individualized healthcare plan must be developed by the school nurse and parent to be shared with appropriate school personnel. As the student's licensed healthcare provider, I confirm that the student has a diagnosis of seizures.

☐ This medication is necessary during the school day. Trained personnel will administer this medication.

Give emergency medication if:	Medication	Dose	Route	Call
● If seizure lasts ___ minutes or longer ● If ___ or more consecutive seizures with or without a period of consciousness (in ___ minutes) ● Other:	☐ Midazolam ☐ Diazepam ☐ Lorazepam ☐ Other (specify):	_____ mg _____ ml	☐ Nasal ☐ Rectal ☐ Other	Always call 911, the parent, and the school nurse

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

Additional instructions for administration:

Additional orders:

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 (or principle designee if no school nurse)

☐ Signed by prescriber and parent ☐ Medication is appropriately labeled ☐ Medication log generated

Medication is kept: ☐ Health office ☐ Front office ☐ Other (specify-must be locked):

IHP/EAP distributed to "need to know" staff:
☐ Front office/administration ☐ PE teacher(s) ☐ Teacher(s) ☐ Transportation staff
☐ Other (specify):

School nurse signature:	Date: