

# Seizure rescue medication management order

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| <b>Seizure – medication management order</b><br><b>Seizure rescue medication authorization</b><br>(In accordance with UCA 53G-9-505)<br><b>Utah Department of Health &amp; Human Services/</b><br><b>Utah State Board of Education</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                | Healthcare provider: |           | Picture |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                | School year:         |           |         |
| 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.<br>Seizures other than tonic-clonic: rescue medication can only be given by an RN, parent, or EMS.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                |                      |           |         |
| <input type="checkbox"/> Yes <input type="checkbox"/> No I certify that I have previously administered the seizure rescue medication in a non medically-supervised setting without complication.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                |                      |           |         |
| <input type="checkbox"/> Yes <input type="checkbox"/> No I certify my child has previously stopped having a full body prolonged or convulsive seizure activity as a result of receiving this medication.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                |                      |           |         |
| <b>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.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                |                      |           |         |
| <input type="checkbox"/> Yes <input type="checkbox"/> No I certify my student's healthcare provider has prescribed a seizure rescue medication for him/her.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                |                      |           |         |
| <input type="checkbox"/> Yes <input type="checkbox"/> 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.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                |                      |           |         |
| <input type="checkbox"/> Yes <input type="checkbox"/> 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:     |         |
| Continued on next page                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                |                      |           |         |

## Seizure medication management order

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| Student name:                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                            | Date of birth:       | School year:                                                                                        |                                                   |
| <b>Prescriber to complete</b>                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                            |                      |                                                                                                     |                                                   |
| <p>Emergency seizure rescue medication</p> <p>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.</p> <p><input type="checkbox"/> This medication is necessary during the school day. Trained personnel will administer this medication.</p> |                                                                                                                                                            |                      |                                                                                                     |                                                   |
| Give emergency medication if:                                                                                                                                                                                                                                                                                                                                                                                                                                       | Medication                                                                                                                                                 | Dose                 | Route                                                                                               | Call                                              |
| <ul style="list-style-type: none"> <li>If seizure lasts ___ minutes or longer</li> <li>If ___ or more consecutive seizures with or without a period of consciousness (in ___ minutes)</li> <li>Other:</li> </ul>                                                                                                                                                                                                                                                    | <input type="checkbox"/> Midazolam<br><input type="checkbox"/> Diazepam<br><input type="checkbox"/> Lorazepam<br><input type="checkbox"/> Other (specify): | ___ mg<br><br>___ ml | <input type="checkbox"/> Nasal<br><input type="checkbox"/> Rectal<br><input type="checkbox"/> 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:                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                            |                      |                                                                                                     |                                                   |
| <b>Prescriber signature</b>                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                            |                      |                                                                                                     |                                                   |
| 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:                                                                                               |                                                   |
| <b>School nurse signature (or principle designee if no school nurse)</b>                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                            |                      |                                                                                                     |                                                   |
| <input type="checkbox"/> Signed by prescriber and parent <input type="checkbox"/> Medication is appropriately labeled <input type="checkbox"/> Medication log generated                                                                                                                                                                                                                                                                                             |                                                                                                                                                            |                      |                                                                                                     |                                                   |
| Medication is kept: <input type="checkbox"/> Health office <input type="checkbox"/> Front office <input type="checkbox"/> Other (specify-must be locked):                                                                                                                                                                                                                                                                                                           |                                                                                                                                                            |                      |                                                                                                     |                                                   |
| IHP/EAP distributed to "need to know" staff:<br><input type="checkbox"/> Front office/administration <input type="checkbox"/> PE teacher(s) <input type="checkbox"/> Teacher(s) <input type="checkbox"/> Transportation staff<br><input type="checkbox"/> Other (specify):                                                                                                                                                                                          |                                                                                                                                                            |                      |                                                                                                     |                                                   |
| School nurse signature:                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                            |                      | Date:                                                                                               |                                                   |