SEIZURE Medication/Management Orders (SMMO) Utah Department of Health/Utah State Board of Education In Accordance with UCA 53A-11-603.5	PCH Pediatric Neurology Clinic 801-213-3599 Fax: 801-587-7539	Other provider:

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

SEIZURE INFORMATION		
Seizure Type/Description	**Length**	**Frequency**

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 Student has received a first dose of this medication in a non-medically-supervised setting without a complication.

If No, medication cannot be given by a trained volunteer. Can only be given by an RN, parent, or EMS.

☐ Yes ☐ No Student has previously ceased having a full body prolonged or convulsive seizure as a result of receiving this medication.

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:

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Student Name:	**DOB:**

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 ___ 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**

☐ 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, other:

Additional instructions for administration:

VAGUS NERVE STIMULATOR

☐ This student has a Vagus Nerve Stimulator. Trained personnel should and will be trained on magnet use. Describe magnet use:

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: