

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:
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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:
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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
<ul style="list-style-type: none"> • If seizure lasts ___ minutes or greater • If ___ or more consecutive seizures with or without a period of consciousness (in ___ minutes) • Other _____ 	<input type="checkbox"/> Midazolam (Versed) (Dose must be provided in 2 syringes) <input type="checkbox"/> Diazepam (Diastat) <input type="checkbox"/> Other _____	_____ mg _____ ml	<input type="checkbox"/> Nasal <input type="checkbox"/> Rectal <input type="checkbox"/> 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: