SEIZURE - Medication/Management Order (SMMO) **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:	DOB:	Grade:	School:
Parent:	Phone:		Email:
Physician:	Phone:		Fax:
School Nurse:	School Phone:		Fax:

SEIZURE INFORMATION

Seizure Type/Description	**Length**	**Frequency**

PARENT TO COMPLETE (must be completed by parent prior to sending to 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 the parent/guardian has previously administered the seizure rescue medication in a non medically-supervised setting without a complication.

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

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

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

☐ Yes ☐ No I request the school identify and train school employees who are willing to volunteer to receive training to administer a seizure rescue medication.

☐ Yes ☐ No I authorize a trained school employee volunteer to administer the seizure rescue medication.

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 the responsibility of the parent/guardian to notify the school nurse of any change in the student's health status, care or medication order. I authorize school staff to administer medication described below to my student. 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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Seizure Medication Management Order (SMMO)

Student Name:	**DOB:**	**School Year:**

PRESCRIBER TO COMPLETE

EMERGENCY SEIZURE RESCUE MEDICATION

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. 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 greater • 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, parent and 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 (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
☐ Other (specify):

School Nurse Signature:	Date: