SEIZURE MEDICATION/MANAGEMENT ORDERS (SMMO)

Kauri Sue Hamilton School
Phone: 801-856-8500 Fax: 801-567-8521

STUDENT INFORMATION

Student:	DOB:	Nurses: KSHS Nursing
Parent:	Phone:	Email:
Physician:	Phone:	Fax:

SEIZURE INFORMATION

Seizure Type	Length	Frequency	Description--*see below

When student has seizure these signs are frequently seen: *mark all that apply

O Sudden cry or squeal	*O Falling down*	*O Rigidity/stiffness*	*O Thrashing/jerking*
O Loss of bowel/bladder control	*O Shallow breathing*	*O Stops breathing*	*O Blue color to lips*
O Froth from mouth	*O Gurgling or grunting noises*	*O Loss of consciousness*	*O Staring*
O Lip smacking	*O Eye movement______________*	*O Other:_________________________*	

Parent: complete the above section, read and sign below, obtain signature from Health Care Provider and return to school nurse.

As this student's parent/guardian, 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 infromation contained in ths 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:

EMERGENCY SEIZURE 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 educationemployees without parental consent. As the student's provider I confirm that the student has a diagnosis of seizures.

Give Emergency Medication IF:	Medication	Dose	Route
O IF GTC seizure lasts ___________minutes or greater	O Midazolam (Versed)	______________ml	O Nasal
O Other____________________ ____________________________ ____________________________ _________________	O Diazepam (Diastat)	______________mg	O Rectal
	O Other ______________		O Other _____________

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

Additional instructions for administration:

SPECIAL CONSIDERATIONS

Does the student have a Vagus Nerve Stimulator? O Yes O No If YES, describe magnet use:

Special Considerations and Precautions (regarding school activities, sports, trips, helmet, height restriction, etc):

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: _________________________