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:

Student information:

Student name:	Classroom:	Date of birth:
Parent name:	Phone:	Email:
Physician name:	Phone:	Fax:
School nurse:	Phone:	Fax:

Seizure Information

Seizure types/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 AND student has received rescue medication at least once prior:

- ☐ Rescue medication may be administered by a trained volunteer. ~or~
- ☐ Rescue medication can only be given by an RN, parent, or EMS.

- I certify that I have previously administered the seizure rescue medication in a non medically supervised setting without complication. ☐ Yes ☐ No
- I certify my child has previously stopped having a full body prolonged or convulsive seizure activity as a result of receiving this medication. ☐ Yes ☐ No

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.

- I certify my student's healthcare provider has prescribed a seizure rescue medication for him/her. ☐ Yes ☐ No
- I give permission for the school to identify and train school employees who are willing to volunteer to receive training to administer a seizure rescue medication to my child. ☐ Yes ☐ No
- I give permission for a trained school employee volunteer to administer the seizure rescue medication to my child.☐ Yes ☐ No

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. New orders are required each school year. I am responsible for maintaining necessary supplies, medications, and equipment.

Parent signature:	**Date:**

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Student name:	Date of birth:	School year:

Prescriber to complete:

Emergency seizure rescue medication- 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.

☐ This medication is medically necessary during the school day.

Give emergency medication:	Medication- Dose- Route-	Call
☐ If seizure lasts _____ minutes or longer. ☐ If _____ or more consecutive seizures (with or without a period of consciousness) within _____ minutes) ☐ Other: _____	☐ Midazolam ☐ Versed nasal _____mg/_____ml per one nostril **OR** per both nostrils (please circle) ☐ Nayzilam nasal _____mg per one nostril **OR** per both nostrils (please circle) ☐ Diazepam ☐ Valtoco nasal _____mg per one nostril **OR** per both nostrils (please circle) ☐ Diastat rectal _____mg per rectum ☐ Lorazepam _____mg per _____ ☐ Other (specify): _____	Call parents and school nurse

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

Implanted Devices: (if applicable)

This student has a:

- ☐ Responsive Neurostimulation (RNS)
- ☐ Deep Brain Stimulation (DBS)
- ☐ Vagus Nerve Stimulator (VNS): personnel will be trained on device use.

Describe magnet use:

- ☐ Swipe magnet at onset of seizure activity. Magnet will travel with student while at school.
- ☐ DO NOT use magnet. No need for magnet to travel with student at school
- ☐ Other_____

Prescriber name: _____ This order can only be signed by an MD/DO; nurse practitioner, certified physician's assistant, or a provider with prescriptive practice.	**Phone:** **Fax:**
Prescriber signature:	**Date:**

School nurse signature (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):

School nurse signature: _____ Date: _____