

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:	
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: <input type="checkbox"/> Rescue medication may be administered by a trained volunteer. ~or~ <input type="checkbox"/> Rescue medication can only be given by an RN, parent, or EMS.			
<ul style="list-style-type: none"> - I certify that I have previously administered the seizure rescue medication in a non medically supervised setting without complication. <input type="checkbox"/> Yes <input type="checkbox"/> No - I certify my child has previously stopped having a full body prolonged or convulsive seizure activity as a result of receiving this medication. <input type="checkbox"/> Yes <input type="checkbox"/> 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.			
<ul style="list-style-type: none"> - I certify my student's healthcare provider has prescribed a seizure rescue medication for him/her. <input type="checkbox"/> Yes <input type="checkbox"/> 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. <input type="checkbox"/> Yes <input type="checkbox"/> No - I give permission for a trained school employee volunteer to administer the seizure rescue medication to my child. <input type="checkbox"/> Yes <input type="checkbox"/> 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:
Continued on next page			

Student name: _____	Date of birth: _____	School year: _____
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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
<input type="checkbox"/> If seizure lasts _____ minutes or longer. <input type="checkbox"/> If _____ or more consecutive seizures (with or without a period of consciousness) within _____ minutes) <input type="checkbox"/> Other: _____	<input type="checkbox"/> Midazolam <input type="checkbox"/> Versed nasal _____mg per <u>one nostril</u> OR per <u>both nostrils</u> (please circle) <input type="checkbox"/> Nayzilam nasal _____mg per <u>one nostril</u> OR per <u>both nostrils</u> (please circle) <hr/> <input type="checkbox"/> Diazepam <input type="checkbox"/> Valtoco nasal _____mg per <u>one nostril</u> OR per <u>both nostrils</u> (please circle) <input type="checkbox"/> Diastat rectal _____mg per rectum <hr/> <input type="checkbox"/> Lorazepam _____mg per _____ <input type="checkbox"/> 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: _____
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Prescriber signature: _____	Date: _____
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School nurse signature

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:** _____