Emergency Medication Plan -

Seizure Management

for education and care

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| This information is confidential and will be available only to staff trained to manage seizures, those providing training to manage seizures, and emergency medical personnel.The agreement section is completed by a neurologist, paediatrician, specialist physician, general practitioner or neurology nurse. Authorisation/release is completed by the parent or guardian; or the adult student.The authorisation/release and agreement sections must be completed for the medication to be administered in an education or care setting.*Emergency medication management plans that are modified, overwritten or illegible will* ***NOT*** *be accepted.*  |
| Name of child/young person: |  |
| Date of birth: |       | Date: |       |
| Education or care service: |       |

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| **ADMINISTRATION INSTRUCTIONS** *(print clearly)* |
| Seizure type: Choose an item.  Route of administration:Choose an item.*(Intransal/Buccal)* |
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|  | **GIVE MIDAZOLAM:** |  | **DOSE OF MIDAZOLAM**Use only plastic ampoule (5mg/1mL) or Zyamis pre-filled syringe. Do not administer if expired.  |  |
|  | [ ]  | Immediately seizure begins, **OR** |  | [ ]  | Give one ampoule**, OR** |  |
|  | [ ]  | For seizures lasting more than minutes, **OR** |  | [ ]  | Give Choose an item. *Discard 9 drops, then administer one drop at a time until the remaining contents of ampoule* Choose an item. *is used,* ***OR*** |  |
|  | [ ]  | Other instruction:  |  | [ ]  | Give  drops*Discard*  *drops, then administer one drop at a time until the remaining contents of ampoule are used,* ***OR*** |  |
|  |  |  |  | [ ]  | Zyamis pre-filled syringe Choose an item. |  |
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| **AGREEMENT** * ***I agree the medication instructions as written above are appropriate for administration in the education or care settings***
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| Name | Professional role  |
| Address | Telephone  |
| Signature or email  | Date |

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| **AUTHORISATION AND RELEASE** *(please print clearly)** ***I authorise the medication as instructed above to be administered in the education or care settings***
* ***I approve the release of this information to staff trained to manage seizures or providing training for managing seizures, and emergency personnel.***
* ***I understand the medication provided must have a pharmacy label that matches the information in the Emergency Medication Management Plan, else the medication will not be administered.***
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| Parent/ guardian or adult student/client    Please print clearly |
| Signature or email  | Date  |

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| **REVIEW** |
| *This emergency medication management plan remains current until superseded due to different management or doses being required.* *Parent/ guardian/ adult student to sign every 12 months that this continues as the current plan.*  |
| **Date** | **Name** | **Relationship** | **Signature or Email** |
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