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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Emergency Seizure Medication Order** | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Child/Adolescent: | | | |  | | | | | | | | | | | | Date of Birth: | | | | | | | | |  | | |
| Parent/Guardian: | | | |  | | | | | | | | | | | | Contact Number(s): | | | | | | | | |  | | |
| Treating Clinician: | | | |  | | | | | | | | | | | | Contact Number(s): | | | | | | | | |  | | |
| **Type of Seizure for which Medication has been prescribed** | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Seizure Type** | | | **Description of the seizure activity for which medication has been prescribed** | | | | | | | | | | | | | | | | | | | | | | | **Medication** | |
| 1 |  | |  | | | | | | | | | | | | | | | | | | | | | | |  | |
| 2 |  | |  | | | | | | | | | | | | | | | | | | | | | | |  | |
| **Midazolam (5mg/1ml)** | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **How is Midazolam to be given?** | | | | | | | | | | In nose (intranasal) | | | | | | | | | | Inside cheek (buccal) | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **When is Midazolam to be given?** | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| As soon as the seizure starts | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| If the seizure lasts longer than | | | | | | | |  | | | minutes | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| If | |  | | | | seizure as described above occur within | | | | | | | | | | | |  | | | minutes/hours of each other | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| If | |  | | | | seizure as described above occur within | | | | | | | | | | | |  | | | minutes/hours of each other | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Special circumstances (please specify): | | | | | | | | | | | |  | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Patient Weight: | | | | | | | | | | | | Patient Allergies: | | | | |  |  | | | | |  | | | | |
|  | | | | |  | | | | | |  | | | |  | | | | | | |  | | | | | |
| **Midazolam dose to be given:** | | | | |  | | | | | | **mls**, which is | | | |  | | | | | | | **mg** | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Other Emergency Seizure Medication** | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Other Medication name:** | | | | | |  | | | | | | | | | | | | |  | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **When is medication to be given?** | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| As soon as the seizure starts | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| If the seizure lasts longer than | | | | | | | |  | | | minutes | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| If | |  | | | | seizure as described above occur within | | | | | | | | | | | |  | | | | | | minutes / hours of each other | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| If | |  | | | | seizure as described above occur within | | | | | | | | | | | |  | | | | | | minutes / hours of each other | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Special circumstances (please specify): | | | | | | | | | | | |  | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Dose to be given:** | | | | | **Give** | |  | | | | | | |  | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **General First Aid Principles** | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Call for Ambulance on 000 if:** | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name of Prescribing Doctor: | | | | | | | | | Signature: | | | |  | | | | | | | | | | Date: | | | |  |
| Name of Parent: | | | | | | | | | Signature: | | | |  | | | | | | | | | | Date: | | | |  |