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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: |  |