

Seizure Rescue Medication Management Order (SMMO)

SEIZURE - Medication/Management Order (SMMO) Seizure Rescue Medication Authorization (In Accordance with UCA 53G-9-505) Utah Department of Health/Utah State Board of Education		Healthcare Provider:		Picture
		School Year:		
STUDENT INFORMATION				
Student:	DOB:	Grade:	School:	
Parent:	Phone:	Email:		
Physician:	Phone:	Fax:		
School Nurse:	School Phone:	Fax:		
SEIZURE INFORMATION				
Seizure Type/Description		Length	Frequency	
PARENT TO COMPLETE (must be completed by parent prior to sending to healthcare provider)				
If Seizures are full body tonic-clonic, rescue medication may be administered by a trained volunteer.				
Seizures other than tonic-clonic, rescue medication can only be given by an RN, parent or EMS.				
<input type="checkbox"/> Yes <input type="checkbox"/> No	I certify that the parent/guardian has previously administered the seizure rescue medication in a non medically-supervised setting without a complication.			
<input type="checkbox"/> Yes <input type="checkbox"/> No	I certify student has previously ceased having a full body prolonged or convulsive seizure activity as a result of receiving this medication.			
If No to either, medication cannot be given by a trained volunteer. Can only be given by an RN, parent, or EMS.				
<input type="checkbox"/> Yes <input type="checkbox"/> No	I certify my student's healthcare professional has prescribed a seizure rescue medication for him/her.			
<input type="checkbox"/> Yes <input type="checkbox"/> No	I request the school identify and train school employees who are willing to volunteer to receive training to administer a seizure rescue medication.			
<input type="checkbox"/> Yes <input type="checkbox"/> No	I authorize a trained school employee volunteer to administer the seizure rescue medication.			
Parent Signature:			Date:	
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 the responsibility of the parent/guardian to notify the school nurse of any change in the student's health status, care or medication order. I authorize school staff to administer medication described below to my student. If prescription is changed a new SMMO must be completed before the school staff can administer the medication. Parents/Guardian are responsible for maintaining necessary supplies, medications and equipment.				
Parent Signature:			Date:	
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Student Name:		DOB:	School Year:	
PRESCRIBER TO COMPLETE				
EMERGENCY SEIZURE RESCUE MEDICATION				
In accordance with these orders, an Individualized Health Care Plan (IHP) 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.				
<input type="checkbox"/> This medication is necessary during the school day. Trained personnel will be allowed to administer this medication.				
Give Emergency Medication IF:	Medication	Dose	Route	Call
<ul style="list-style-type: none"> If seizure lasts ___ minutes or greater If ___ or more consecutive seizures with or without a period of consciousness (in ___ minutes) Other: 	<input type="checkbox"/> Midazolam <input type="checkbox"/> Diazepam <input type="checkbox"/> Lorazepam <input type="checkbox"/> Other (specify):	_____ mg _____ ml	<input type="checkbox"/> Nasal <input type="checkbox"/> Rectal <input type="checkbox"/> Other	ALWAYS call 911, parent and School Nurse
Common potential side effects: respiratory depression, nasal irritation, memory loss, drowsiness, fatigue. other:				
Additional instructions for administration:				
Additional orders:				
IMPLANTED DEVICES				
This student has a:				
<input type="checkbox"/> Responsive Neurostimulation (RNS) <input type="checkbox"/> Deep Brain Stimulation (DBS) <input type="checkbox"/> Vagus Nerve Stimulator (VNS): trained personnel will be trained on device use. Describe magnet use:				
PRESCRIBER SIGNATURE				
This order can only be signed by an MD/DO; Nurse Practitioner, Certified Physician's Assistant or a provider with prescriptive practice.				
Prescriber Name:			Phone:	
Prescriber Signature:			Date:	
SCHOOL NURSE (or principle designee if no school nurse)				
<input type="checkbox"/> Signed by prescriber and parent <input type="checkbox"/> Medication is appropriately labeled <input type="checkbox"/> Medication log generated				
Medication is kept: <input type="checkbox"/> Health Office <input type="checkbox"/> Front Office <input type="checkbox"/> Other (specify-must be locked):				
IHP/EAP distributed to 'need to know' staff:				
<input type="checkbox"/> Front office/administration <input type="checkbox"/> PE teacher(s) <input type="checkbox"/> Teacher(s) <input type="checkbox"/> Transportation <input type="checkbox"/> Other (specify):				
School Nurse Signature:			Date:	