



Government of South Australia

**CONFIDENTIAL**

# Emergency Medication Plan - Seizure Management for education and care

HSP153

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:

## ADMINISTRATION INSTRUCTIONS (print clearly)

Seizure type: Choose an item.	Route of administration: Choose an item. <i>(Intransal/Buccal)</i>
<b>GIVE MIDAZOLAM:</b> <input type="checkbox"/> Immediately seizure begins, <b>OR</b> <input type="checkbox"/> For seizures lasting more than minutes, <b>OR</b> <input type="checkbox"/> Other instruction:	<b>DOSE OF MIDAZOLAM</b> <i>Use only plastic ampoule (5mg/1mL) or Zyamis pre-filled syringe. Do not administer if expired.</i> <input type="checkbox"/> Give <b>one ampoule</b> , <b>OR</b> <input type="checkbox"/> Give <b>Choose an item.</b> <i>Discard 9 drops, then administer one drop at a time until the remaining contents of ampoule <b>Choose an item.</b> is used, <b>OR</b></i> <input type="checkbox"/> Give <input type="text"/> drops <i>Discard <input type="text"/> drops, then administer one drop at a time until the remaining contents of ampoule are used, <b>OR</b></i> <input type="checkbox"/> Zyamis pre-filled syringe <b>Choose an item.</b>

### AGREEMENT

- I agree the medication instructions as written above are appropriate for administration in the education or care settings

Name	Professional role
Address	Telephone
Signature or email	Date

### 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.

Parent/ guardian or adult student/client <small>Please print clearly</small>	
Signature or email	Date

### 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

EMERGENCY MEDICATION MANAGEMENT PLAN  
Health Support Planning

