Ministry of Education and Child Care
BRITISH COLUMBIA

Medical Order Form
For Standardized In School Seizure Rescue Interventions

Student's Name: ______________________ **Date of Birth:** ____________

PART 3: MEDICAL ORDERS FOR SEIZURE RESCUE INTERVENTION (LORAZEPAM / MIDAZOLAM / VNS) IN SCHOOL SETTING

SEIZURE MEDICATION AND TREATMENT INFORMATION - Standard Order Form
*Instructions: **Physician to complete.** This information will guide school personnel (non-medical people) in the administration of lorazepam or midazolam or the use of the Vagus Nerve Stimulator (VNS) at school.*

1. Daily anti-seizure scheduled medication(s) needed <u>at school</u> (that **cannot** be scheduled before / after school):

Medication	Dosage	Frequency	Time of day (if taken at school)	Comments

2. Calling for emergency help:
   ☒ Call 911: ☐ at start of seizure ☐ after ____ mins of seizing ☐ if seizure has not stopped ____ minutes after the rescue medication/VNS was given ☐ Other (specify): ______________________________
   ☒ Call parent/guardian: ☒ when lorazepam/midazolam given as student must be picked up from school within 30 minutes for ongoing care or 911 will be called ☐ at start of seizure ☐ after ____ mins of seizing ☐ Other (specify): ____________
3. Emergency Medication/Intervention in the school setting (tick all that apply):
   ☐ Student <u>does</u> <u>not</u> need/receive any seizure rescue medication in the school setting.
   ☐ Student <u>requires</u> seizure first aid ONLY as per this seizure action plan.
   ☐ Student <u>requires</u> seizure first aid and seizure rescue intervention in the school setting as ordered below.

Rescue Intervention	Dosage	Administration Instructions (timing & method) *(Medication must have expiry date labelled)*
Lorazepam (buccal *ONLY*)	_____ mg = _____ tablet(s)	☐ Single seizures: Administer **lorazepam** if seizure lasts for longer than **5 minutes.** ☐ Cluster seizures: Administer **lorazepam** if seizures occur more than **3 times in 30 minutes.** **NOTE: ONLY one dose** of lorazepam will be administered in school.
Midazolam (intranasal *ONLY*) (volume *must be* rounded up/down to the nearest 0.0 or 0.5 ml)	_____ mg = _____ ml of **5mg/ml concentration ONLY**	☐ Single seizures: Administer **midazolam** if seizure lasts longer than **5 minutes.** ☐ Cluster seizures: Administer **midazolam** if seizures occur more than **3 times in 30 minutes.** **NOTE: ONLY one dose** of midazolam will be administered in school. ☒ A 3 ml luer lock syringe ONLY <u>must be pre-marked</u> with the student's dosage. Marking this is the responsibility of the family/pharmacy/primary care or clinic team.
Vagus Nerve Stimulator (VNS) (this can be used in combination with or without lorazepam or midazolam order above)		☐ **Swipe** once at onset of seizure. If seizure does not stop, swipe once every ____ **seconds** to a maximum of ____ **times.** If seizure has not stopped after _______ **minutes,** ☐ provide rescue medication as per above, and/or ☐ call 911. ☐ If VNS has already been swiped and seizure stopped, but then student seizes again while waiting for parent/delegate/EMS, VNS may: ☐ (1) not be used again or, ☐ (2) be swiped again (as per orders above) ____ **minutes** after last swipe.

I, the undersigned Neurologist/Physician agree that the:
☐ student's seizure care can be safely managed as above in the school setting.
☐ above orders for the school setting are the same that have been prescribed for the home/other community contexts.
☐ family has been trained in the above and is capable of administration in the absence of a health care provider.
☐ family can communicate with the non-medical school staff about the above ordered rescue interventions.

Physician Name: ______________________________ Date: ____________________

Physician Signature: ___________________________ Clinic Phone Number: ______________

PART 2: PARENT/GUARDIAN AND SCHOOL COMPLETE

SPECIAL CONSIDERATION & PRECAUTIONS

9. Describe any other considerations or precautions related to your child's seizures. Consider the following areas: physical functioning, learning, physical education (gym), behaviour, mood, bus transportation, fieldtrips, and recess/lunch.

____
____
____
____
____
____

10. I confirm I have discussed my child's seizures and plan with school contact.

☐ YES ☐ NO

Name: ____________________ Relationship: ____________________

Telephone: ____________________ Email: ____________________

Date: ____________________ Signature: ____________________

____________________ ____________________ ____________________
Parent/Guardian Name | Parent/Guardian Signature | Date:

____ ____________________
School Based Team Lead or School Administrator | Date: