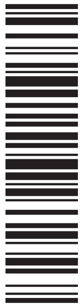
NSW GOVERNMENT | Health

Facility:

PAEDIATRIC EPILEPSY EMERGENCY SEIZURE MEDICATION PLAN FOR PARENTS/CARERS

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. _______ / _______ / _______	M.O.
ADDRESS	
LOCATION / WARD	

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE



SMR130060

Emergency Seizure Medication Plan

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

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/s as described above occurs within _________ minutes/hours of each other

☐ If ____________________________________ seizure/s as described above occurs within _________ minutes/hours of each other

☐ Special circumstances (please specify):

Midazolam dose to be given: ☐ **mL,** which is ☐ **mg.** **Midazolam strength:** ☐ **mg per mL**

Patient Weight: **Patient Allergies:**

Other Emergency Seizure Medication

Medication: ____________________________________

Dose: ____________________________________

When to be given: ____________________________________

Medication: ____________________________________

Dose: ____________________________________

When to be given: ____________________________________

Call 000 for an Ambulance if:

This form should be regularly reviewed with your treating Clinician.

Name of Treating Clinician.	Signature:	Date:
Name of Parent / Guardian:	Signature:	Date:

Further information: Paediatric Epilepsy Network NSW (www.pennsw.org.au) or Epilepsy Action Australia (https://www.epilepsy.org.au/)

This document must be photocopied for the health record

NO WRITING

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BINDING MARGIN - NO WRITING

Holes Punched as per AS2828.1: 2019

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