Epilepsy Action Australia
life changing impact

ADMINISTRATION ORDER
EMERGENCY MEDICATION FOR SEIZURES

To be completed by prescribing doctor only

NAME: _____ **DATE OF BIRTH:** _____

KNOWN ALLERGIES: _____ **WEIGHT (optional):** _____

DESCRIPTION OF SEIZURE FOR WHICH THE EMERGENCY MEDICATION HAS BEEN PRESCRIBED:

NAME OF MEDICATION: _____

STRENGTH / VOLUME OF MEDICATION: _____ mg in _____ mls/drops/spray pumps/wafer/tablets

DOSE TO BE GIVEN:

- ☐ Give _____ mgs which is _____ mls
- ☐ Give _____ mgs which is _____ drops
- ☐ Give _____ mgs which is _____ spray pumps
- ☐ Give _____ mgs which is _____ wafer
- ☐ Give _____ mgs which is _____ tablets (instructions: _____)

ROUTE:

- ☐ in nose (intranasal)
- ☐ inside cheek (buccal)
- ☐ via MAD
- ☐ rectally
- ☐ via PEG
- ☐ in mouth to be swallowed

GIVE THE MEDICATION:

- ☐ As soon as the seizure starts
- ☐ If the seizure lasts longer than ____ minutes
- ☐ If ____ seizure/s as described above occur within ____ minutes/hours
- ☐ Special circumstances *(please specify)*

CALL AN AMBULANCE (DIAL 000)

- ☐ As soon as the seizure starts
- ☐ As soon as the medication is given
- ☐ If the seizure continues for more than ____ minutes after the medication has been given
- ☐ If ____ seizure/s as described above occur within ____ minutes/hours
- ☐ Special circumstances *(please specify)*

SPECIAL INSTRUCTIONS:

NAME OF PRESCRIBING DOCTOR: _____ **CONTACT NUMBER:** _____

SIGNATURE: _____ **DATE:** _____ **ORDER VALID UNTIL:** _____

