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** (Child)**:**

**Description of seizure for which the emergency medication has been prescribed:**

**NAME OF MEDICATION:** _____

**STRENGTH / VOLUME OF MEDICATION:** _____ mg in _____ mls **OTHER** _____

**DOSE TO BE GIVEN:**

☐ Give _____ mgs which is _____ mls **OTHER** _____

**ROUTE TO GIVE THE MEDICATION:**

☐ in nose (intranasal) ☐ inside cheek (buccal) ☐ rectally ☐ other _____

**WHEN TO 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)*

**OTHER RELEVANT INSTRUCTIONS:**

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

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