

**Division of Developmental Disabilities Services
Community Services**

Seizure Rescue Medication Order Form

Name: _____
Date of Birth: _____

Date: _____
MCI Number: _____

When to call 911:

- Seizure continues _____ minutes after giving rescue medication
- Rescue medication is needed more than _____ in ___ hours (24, 48, 72) (**Circle One**)
- Other care needed: _____
- Seizure in water
- The seizure behavior is different from other episodes (frequency/severity)
- Difficulty breathing; change in skin color
- Serious injury occurs or suspected

Seizure Type	What Happens	How Long it Lasts	How Often

Seizure Rescue Medication(s) Order: (List in order of Administration)

Medication Name	Dosage	Route	Administer After (cluster, # or length)

(Should be the same as on the prescription)

After Rescue Medication you MUST:

- Stay with the person
- Make note and document the following
 - Changes in breathing rate
 - Changes in skin color
 - Drowsiness that exceeds beyond the 4-hour period of observation
- Other things to monitor: _____

Call my office at telephone number () - if any of the following occur:

- Seizure frequency or severity is different from other episodes
- If you have given a dose of rescue medication
- Other reasons to call: _____

Healthcare Provider Signature

Date

**Form must be reviewed at each appointment and rewritten within a 1-year period.
Form must be attached to the Risk Section of the Person-Centered Plan and Documented on the
Significant Medical Conditions and Medical Alert form.**