



Epilepsy Health Care plan for Children & Young People requiring emergency seizure medication (Midazolam)

PERSONAL INFORMATION:

Name: _____ DoB: _____

NHS Number: _____

Date Completed: _____

Expiry Date of Plan: _____

CONTACT INFORMATION

Family contact 1:

Name: _____

Relationship: _____

Tel: (Home) _____

Tel: (Mobile) _____

Tel: (Work) _____

Family contact 2:

Name: _____

Relationship: _____

Tel: (Home) _____

Tel: (Mobile) _____

Tel: (Work) _____

Clinic / Hospital Contact:

Name: _____

Title: _____

Tel No: _____

G. P. Contact:

Name: _____

Practice: _____

Tel No: _____

OTHER MEDICAL CONDITIONS OR ALLERGIES:



Name: _____ DOB: ____/____/____ NHS Number: _____

Seizure classification and/ or description of seizures which may require buccal midazolam

Seizure type 1:

Usual duration of seizure:

.....
.....

Seizure type 2:

Usual duration of seizure:

.....
.....

Seizure type 3:

Usual duration of seizure:

IMMEDIATE ACTIONS - Follow epilepsy first aid as per training

Time the seizure

Protect from injury

Do not move unless in immediate danger

Do not restrain – let the seizure run it's course

Do not put anything in the mouth

DO NOT GIVE BUCCAL MIDAZOLAM IF:

1. Buccal Midazolam has been given in previous 6 hours (stays in system for 6 hours)
2. The child has sustained an injury to the mouth requiring hospital consultation as you may not be able to administer the medication correctly or safely

MIDAZOLAM TREATMENT PLAN

1. When should buccal midazolam be administered:

2. Initial dose: give milligrams (mg). Record amount and time given.

3. What is the child's usual response / reaction (s) to buccal midazolam:

4. Action to take if there are difficulties in the administration of buccal midazolam e.g. vomiting/ spitting/ oral secretions

Call 112 / 999 for an ambulance if buccal midazolam can not be given for any reason

5. DO NOT GIVE MORE THAN THE PRESCRIBED DOSE

6. When should 112 / 999 be dialled for emergency help:

1. THE FIRST TIME BUCCAL MIDAZOLAM IS GIVEN
2. If the seizure has not stopped within minutes of having buccal midazolam
3. As per school/ respite policy

7. Actions when seizure has stopped either with or without buccal midazolam:

Place the child in the recovery position when movements have stopped and if practical

Allow the child to sleep but stay with them and regularly check that they are rousable until fully recovered. Monitor for any further seizure activity

Any concerns dial 112 / 999 for an ambulance

3. The child has sustained a head injury requiring hospital consultation

****RECOVERY POSITION****



1. Kneel next to the person. Place the arm closest to you straight out from the body. Position the far arm with the back of the hand against the near cheek.



2. Grab & bend the person's far knee



3. Protecting the head with one hand, gently roll person toward you by pulling the far knee over & to the ground



4. Tilt the head slightly so that the airway is open. Make sure that the hand is under the cheek. Stay close until help arrives.

Name: _____ DOB: ____/____/____ NHS Number: _____



Signed and agreed:

Registered Healthcare Professionals Agreement:

(Paediatric Consultant, Paediatric Epilepsy Nurse Specialist, Specialist School Nurse)
I agree that the information is accurate and up to date.

Signature: _____ Date: ____/____/____

Print Name: _____ Job Title: _____

Parents / Carer and CYP Agreement:

I agree that the medical information contained in this plan may be shared with individuals involved with’s care (this includes emergency services). I understand that I must notify the school/ other organisation of any changes in writing.

Child & Young Person

Signature: _____ Date: ____/____/____

Print Name: _____

Parent / Guardian

Signature: _____ Date: ____/____/____

Print Name: _____

Agency Representative Agreement:

This arrangement will continue until any changes are made to the health care plan when it is reviewed annually or when informed of necessary changes by parent/carers in writing.

Signature: _____ Date: ____/____/____

Print Name: _____ Job Title _____

FORM COPIED TO:

Designation

Named Contact Point

- | | |
|----------------------|-------|
| 1) Parent / Guardian | _____ |
| 2) Setting | _____ |
| 3) Diabetes Team | _____ |
| 4) School Nurse | _____ |
| 5) | _____ |

Name: _____ DOB: ____/____/____ NHS Number: _____

RECORD OF USE OF BUCCAL MIDAZOLAM ADMINISTRATION

Date of Administration of Buccal Midazolam									
Recorded By									
Seizure Type									
Length and/or Number of Seizures									
Time Dose Administered									
Outcome									
Observations									
Second Dose – Time given (if prescribed)									
Parent / Guardian Informed	Date:	Time:	Date:	Time:	Date:	Time:	Date:	Time:	Date:
Prescribing Medical Practitioner Informed	Date:	Time:	Date:	Time:	Date:	Time:	Date:	Time:	Date:
Other Information									
Witness									
Date of Record:									