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Attach this document to your Epilepsy/Seizure Management Plan. This Emergency Plan should be completed and signed by the prescribing doctor in consultation with the person and/or their family or carer. It is recommended that this plan be reviewed and signed by the person's doctor annually.

## Emergency Medication Management Plan



# Midazolam

## (Zyamis Prefilled Syringe)

(only to be administered by a trained person)

Name:

Date of birth:

Weight:

Administration method

BUCCAL

### 1. FIRST DOSE Midazolam

First dose prefilled syringe = 5 mg 10 mg

#### For single seizures:

As soon as a

(seizure type) begins

If the

(seizure type) continues longer than mins

Special instructions:

#### For clusters of seizures:

When (number)

(seizure type) occurs within mins hrs

Other (please specify):

Special instructions:

### 2. SECOND DOSE Midazolam

Second dose prefilled syringe = 5 mg 10 mg

Not prescribed

OR

If the (seizure type) continues for another mins following the first dose

When another (number) (seizure type) occurs within mins hrs

following the first dose

Other (please specify):

Special instructions:

### 3. Maximum number of Midazolam doses to be given in a 24-hour period

Maximum number:

Client Name DOB:

#### 4. Dial 000 to call the ambulance:

Prior to administering Midazolam

Immediately after administering Midazolam

If the seizure has not stopped                      minutes after giving the Midazolam

If injured or has difficulty with breathing

Other (please specify):

#### 5. Describe what to do after Midazolam has been administered:

- Continue to provide seizure first aid, keeping me safe from injury. Continue to time and monitor the seizure.
- If possible, keep me on my side to protect my airway. If this is not possible, turn my head to the side.
- If in a wheelchair or car seat, leave me seated and continue to support my head and protect my airway.
- Document time Midazolam was given, when ambulance called and when seizure activity stops.
- Stay with me and monitor:
  - For shallow or slow breathing, change of facial colour
  - Other:

#### 6. Prescribing doctor or specialist

Doctor's name:	Telephone:
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Signature:

Date:

#### 7. Storage and family special instructions

**Recommended MIDAZOLAM storage information:**

- **Keep out of reach of children**
- **Protect from light (stored in container provided) and store at room temperature (below 25°C)**
- **Regularly check the expiry date.**

*Any special instructions e.g. storage of medication, when on outings etc.  
or people to contact if emergency medication is given.*

Emergency contact name:	
Relationship:	Telephone:

Signature:

Date:

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**Client Name DOB:**