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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

Rectal Valium

(only to be administered by a trained person)

Name:

Date of birth: Weight:

Administration method

Rectal

1. FIRST DOSE Rectal Valium

First dose = 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 Rectal Valium

Second dose = 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 Rectal Valium doses to be given in a 24-hour period

Maximum number:

Client Name DOB:

4. Dial 000 to call the ambulance:

Prior to administering Rectal Valium

If the seizure has not stopped minutes after giving the Rectal Valium

Other (please specify):

5. Describe what to do after Rectal Valium has been administered:

- Document time Rectal Valium given.
- Keep me on my side and squeeze buttocks together to keep medication in place.
- Rectal Valium may take up to 10 minutes to take effect.
- Maintain privacy.
- Monitor seizure and breathing activity.

6. Prescribing doctor or specialist

Doctor's name:	Telephone:

Signature: Date:

7. Storage and family special instructions

Recommended RECTAL VALIUM storage information:

- **Keep out of reach of children**
- **Protect from light 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: