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| **Midazolam Oromucosal Solution in a Pre-filled Oral Syringe (Buccolam®)**  **First Dose Authorisation Form** |
| I, the prescriber:…………………………………………………………………………(child’s clinician)  …………………………………………………………………………………………(base & contact tel. no.)  give permission for the buccal administration of a **Buccolam® pre-filled oral syringe** by staff who have **attended specific training**. I take full responsibility for this medication to be given as outlined below.  SIGNED:………………………………………………DATED:………………………………………………….. |
| NAME OF CHILD: ...………………………………..………………………… DOB: ………………………..  NHS No: ………………………………School:………………………………………………………………….  Home Address: ……………………………………………………………………………………………………  Other Setting: ……………………………………………………………………………………………………..    **mg**  **Dose to be administered: ONE PR PRE-FILLED ORAL SYRINGE**  ROUTE: BUCCAL  To be given if seizure lasts longer than: ………minutes  Special instructions (if required): ……………………………………………………………………………….....  ……………………………………………………………………………………………………………… |
| **When to call for a Paramedic Ambulance:**   * Whenever any emergency rescue medication is being given to this child for the first time in a   school/setting.   * If the seizure has not resolved after ………minutes following administration of Buccal Midazolam   Oromucosal.   * Other …………………………………………………………………………………………………………………. |
| **Instructions for administration:**  * Break the tamper-proof seal and remove the oral syringe from the protective plastic tube. * **Remove and throw away the oral syringe cap.** * Place the tip of the oral syringe into the buccal area of the child’s mouth, between the cheek and the gum of the * lower jaw by the back teeth. * Slowly drip the Buccolam® solution into this area until the oral syringe is empty. * Remove the oral syringe from the child’s mouth. |
| The authorisation form must be updated annually or whenever there are any changes to the child’s  emergency rescue medication details. |