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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: BUCCALTo be given if seizure lasts longer than: ………minutesSpecial 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 ………………………………………………………………………………………………………………….
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| **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.
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| The authorisation form must be updated annually or whenever there are any changes to the child’s emergency rescue medication details. |