Medical Management Plan SCHOOL YEAR 2024-2024

SEIZURE DISORDER

Student Name:		Date of Birth:						
Physician's Name:		Phone #:						
Address:		Fax #:						
List Known ALLERGIES:								
Type of seizures:								
Please list all medications (HOME & SCHOOL):								
Are medications needed during school hours? Yes No If yes, please list:								
Name of medication	Prescribed Dose/Route		When to use					
If Diastat or Midazolam is ordered, it should be given: At onset of seizure Minutes into seizure after Seizures in a row Is VNS used? (if yes please instruct) Yes No								
Are there activity limits? (if yes please describe) Yes No								
Is protective equipment required? (if yes please describe) Yes No								
Nursing services are recommended for the care of this student during the school day.								
Physicians Signature:			Date:					
For Parent to Complete: 1. When was the last seizure? 2. At what age did the seizure activity begin? 3. Describe the seizure?								
4. How often do seizures occur?								
5. How long do the seizures normally last?								
6. Has the seizure ever lasted longer than 5 minutes? Yes No If yes, how was it handled?								
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Con	tinued Seizure Plan for (Student NAME)									
7. 8.	Does your child lose bowel or bladder control during that your child ever turned blue or stopped breathing of yes, how was it handled?		Yes No Yes No							
9.	Has your child ever required hospitalization due to a solid lifyes, please explain:	seizure	Yes No							
10.	Is there anything that seems to trigger a seizure? If yes, please list:		Yes No							
11.	Does your child experience an aura before a seizure? If yes, please explain:		Yes No							
Othe	r considerations that will assist the school in providing care	for your child:								
Is your child compliant with their current treatment regime? Does your child function independently with medication administration? Are there any activity restrictions for your child? If yes, please list: PARENT to Complete: Authorization for Health Care Provider and School Nurse to Share Information I authorize my child's school nurse to assess my child as it relates to his/her special health care needs and to discuss these needs with my child's physician as needed throughout the school year. I understand this is for the purpose of generating a health care plan for my child. I understand I may withdraw this authorization at any time and that this authorization must be renewed annually. As the parent or guardian of the student named above, I request that the principal or principal's designee assist in the administration of medication/treatment prescribed for my child. I understand that under provisions of Florida Statue 1006.062, there shall be no liability for civil damages as a result of the administration of medication when the person administrating such medication acts as an ordinarily reasonable, prudent person would have acted under the same or similar circumstances. I also grant permission for school personnel to contact the physician listed above if there are any questions or concerns about the medication. I have read the guidelines and agree to abide by them. I authorize the physician to release information about this condition to school personnel.										
	Developed in the Circuit	D.C. I. No.								
	Parent/Guardian Signature	Print Name			Da	ite				
Parer	nt/Guardian	Cell:								
		Work:								
Parer	nt/Guardian:	Cell:								
		Work:								

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