

**Medical Management Plan****SEIZURE DISORDER****SCHOOL YEAR:** \_\_\_\_\_

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Address: \_\_\_\_\_ Fax #: \_\_\_\_\_

List Known ALLERGIES: \_\_\_\_\_

Type of seizures: \_\_\_\_\_

Please list all medications (HOME &amp; 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? \_\_\_\_\_

**Continued Seizure Plan for (Student NAME)** \_\_\_\_\_

- |     |                                                                                                       |     |    |
|-----|-------------------------------------------------------------------------------------------------------|-----|----|
| 7.  | Does your child lose bowel or bladder control during a seizure?                                       | Yes | No |
| 8.  | Has your child ever turned blue or stopped breathing during a seizure?<br>If yes, how was it handled? | Yes | No |
| 9.  | Has your child ever required hospitalization due to a seizure<br>If yes, please explain:              | Yes | No |
| 10. | Is there anything that seems to trigger a seizure?<br>If yes, please list:                            | Yes | No |
| 11. | Does your child experience an aura before a seizure?<br>If yes, please explain:                       | Yes | No |

Other considerations that will assist the school in providing care for your child: \_\_\_\_\_

Is your child compliant with their current treatment regime?

Yes ☐ No ☐

Does your child function independently with medication administration?

Yes ☐ No ☐

Are there any activity restrictions for your child?

Yes ☐ No ☐

If yes, please list: \_\_\_\_\_

**PARENT/GUARDIAN 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 administering 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.

**Parent/Guardian Signature****Print Name****Date**

Parent/Guardian \_\_\_\_\_

Cell: \_\_\_\_\_

Work: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_

Cell: \_\_\_\_\_

Work: \_\_\_\_\_