

# 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 & 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:

- When was the last seizure? \_\_\_\_\_
- At what age did the seizure activity begin? \_\_\_\_\_
- Describe the seizure? \_\_\_\_\_
- How often do seizures occur? \_\_\_\_\_
- How long do the seizures normally last? \_\_\_\_\_
- 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	<input type="checkbox"/>	No	<input type="checkbox"/>
Does your child function independently with medication administration?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Are there any activity restrictions for your child?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>

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 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.

Parent/Guardian Signature	Print Name	Date
Parent/Guardian _____	Cell: _____	
	Work: _____	
Parent/Guardian: _____	Cell: _____	
	Work: _____	