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| **Medical Management Plan** | | **SEIZURE DISORDER** |
| **SCHOOL YEAR** | **2024-2025** | |

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| --- | --- | --- | --- | --- | --- | --- |
| Student Name: | |  | | | Date of Birth: |  |
| **Physician’s Name:** | | |  | | Phone #: |  |
| Address: |  | | | | Fax #: |  |
| List Known ALLERGIES: | | | |  |  |  |

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| Type of seizures: |  | |
| Please list all medications (HOME & SCHOOL): | |  |
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| Are medications needed **during school hours**? | |  | Yes |  | No | |  |
| If yes, please list: | |  |  |  |  | |  |
| Name of medication | Prescribed Dose/Route | | | | | When to use | |
|  |  | | | | |  | |
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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **If Diastat or Midazolam is ordered, it should be given:** |  | At onset of seizure | | |  |  |  | Minutes into seizure | |
|  |  | | |  |  | |  | |
|  | after |  | Seizures in a row | | | | |  |
|  |  |  |  |  | | | | |  |

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| 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 |  |

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| --- | --- | --- | --- |
| *Nursing services are recommended for the care of this student during the school day.* | | | |
| **Physicians Signature:** |  | **Date:** |  |

**For Parent to Complete:**

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| 1. | When was the last seizure? | |  | |
| 2. | At what age did the seizure activity begin? | | |  |
| 3. | Describe the seizure? |  | | |
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| --- | --- | --- | --- | --- | --- | --- |
| 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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| **Continued Seizure Plan for (Student NAME)** |  |

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| --- | --- | --- | --- | --- |
| 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? | Yes | No |  |
|  | If yes, how was it handled? |  |  |  |
|  |  |  |  |  |
| 9. | Has your child ever required hospitalization due to a seizure | Yes | No |  |
|  | If yes, please explain: |  |  |  |
|  |  |  |  |  |
| 10. | Is there anything that seems to trigger a seizure? | Yes | No |  |
|  | If yes, please list: |  |  |  |
|  |  |  |  |  |
| 11. | Does your child experience an aura before a seizure? | Yes | No |  |
|  | If yes, please explain: |  |  |  |

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| --- | --- |
| Other considerations that will assist the school in providing care for your child: |  |
|  | |

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| --- | --- | --- | --- | --- | --- |
| 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: |  |  |  |  |  |

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

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| --- | --- | --- | --- |
| Parent/Guardian |  | Cell: |  |
|  |  | Work: |  |
| Parent/Guardian: |  | Cell: |  |
|  |  | Work: |  |