ST. JOHNS COUNTY SCHOOL DISTRICT
HEALTH SERVICES

SEIZURE DISORDER MEDICAL MANAGEMENT PLAN
SCHOOL YEAR 2016-2017

Student Name: _____ Date of Birth: _____

Physician's Name: _____ Phone #: _____
(Please Print) Fax #: _____

Nursing services are recommended for the care of this student during the school day.
Please list all medications taken at home and school:

_____

_____

Are medications needed **during school hours**? ☐ Yes ☐ No
If yes, please list:

Name of Medication	Amount/Dose	When to use

If Diastat is ordered, it should be given ☐ at onset of seizure ☐____ minutes into seizure ☐ after ____ seizures in a row

Is VNS used? Yes No If yes, please instruct: _____

Are there activity limitations? Yes No If yes, please describe: _____

Is protective equipment required? Yes No If yes, please describe: _____

Physician's Signature_____ Date_____

For Parent to Complete:

1. When was the last seizure? _____
2. What type of seizures does your child have? _____
   _____
3. At what age did seizure activity begin? _____
4. Describe the seizure: _____
   _____
5. How often do seizures occur? _____
6. How long do the seizures normally last? _____

 Seizure management Plan for: _____

7. Has a seizure ever lasted longer than 5 minutes? ☐ Yes ☐ No
   If yes, how was it handled? _____

8. Does your child lose bowel or bladder control during a seizure? ☐ Yes ☐ No

9. Has your child ever turned blue or stopped breathing during a seizure? ☐ Yes ☐ No
   If yes, how was it handled? _____
   _____
   _____

10. Has your child ever required hospitalization due to a seizure? ☐ Yes ☐ No
    If yes, please explain_____
    _____
    _____

11. Is there anything that seems to trigger a seizure? ☐ Yes ☐ No
    If yes, please list _____
    _____

12. Does your child experience an aura before a seizure? ☐ Yes ☐ No
    If yes, please explain_____
    _____

Other considerations that will assist the school in providing safe care for your child:
_____

For 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 regards 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

_____ Ph (C)_____ (WK)_____ (H) _____
Parent/Guardian

_____ Ph (C)_____ (WK)_____ (H) _____
Parent/Guardian

_____ Ph (C)_____ (WK) _____ (H) _____
Emergency Contact

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