

# Medical Management Plan

# SEIZURE DISORDER

SCHOOL YEAR 2024-2025

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? \_\_\_\_\_

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

7. Does your child lose bowel or bladder control during a seizure? 

Yes	No
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8. Has your child ever turned blue or stopped breathing during a seizure? 

Yes	No
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If yes, how was it handled? \_\_\_\_\_
- 
9. Has your child ever required hospitalization due to a seizure 

Yes	No
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If yes, please explain: \_\_\_\_\_
- 
10. Is there anything that seems to trigger a seizure? 

Yes	No
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If yes, please list: \_\_\_\_\_
- 
11. Does your child experience an aura before a seizure? 

Yes	No
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If yes, please explain: \_\_\_\_\_

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 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: _____	