ST. JOHNS COUNTY SCHOOL DISTRICT

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 seizure **should be given:** ☐ At onset of seizure ☐ Minutes into ☐ 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? _____

ST. JOHNS COUNTY SCHOOL DISTRICT

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? Yes

_____

Has your child ever required hospitalization due to a seizure Yes No
If yes, please explain:

_____

Is there anything that seems to trigger a seizure? Yes No
If yes, please list:

_____

Does your child experience an aura before a seizure? Yes No
If yes, please explain:

_____

No If yes, how was it handled?

9.

10. 11.

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 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: _____