Seizure Medical Management Plan

Albuquerque Public Schools **School:** _____ **School Year:** _____ **Grade:** _____

Student Name: _____ **DOB:** _____ **Student #:** _____

Provider Name: _____ **Phone #:** _____ **Fax #:** _____

Seizure Information

Type of seizure: _____**ICD-9:** _____

Description of student's seizure activity:_____

How often do the seizures occur: _____

Typical duration: _____ **Date of last seizure:**_____

Seizure triggers or warning signs: _____

Student's reaction/behaviors after seizure: _____

Dietary Restrictions: ❒Not applicable or ❒Special Diet_____

Activity Restrictions: ❒None or ❒Special Instructions_____

Routine Seizure Management

Routine Medications:

❒ Not applicable

❒ Medication name: _____ Dosage/frequency: _____Given at school: Y N Time:_____

Instructions:_____

❒ Medication name:_____ Dosage/frequency: _____Given at school: Y N Time:_____

Instructions:_____

VNS:

❒This student has Vagal Nerve Stimulator (VNS). Use as follows_____

_____

Emergency Management

For seizures lasting greater than _____minutes OR _____or more seizures in _____hours, CALL 911 and/or refer to Emergency Medication orders below.

Emergency Medications:

❒ Diastat: Dosage/frequency: _____

911 will be called when Diastat is administered

❒ Other: Name _____ Dosage/frequency :_____

_____

SIGNATURES: This Seizure Medical Management Plan has been approved by:

_____ _____ _____

Healthcare Provider **Date** **E-mail**

I give my permission to the school, school nurse, licensed/unlicensed assistive personnel, and other designated staff member(s) to perform and carry out the care tasks as outlined by this Seizure Medical Management Plan for my child, and I acknowledge that I have received a copy of the signed plan. I also consent to the release of the information contained in this plan to all staff and other adults who have custodial care of my child and who may need to know this information to maintain my child's health and safety. I will notify extra-curricular staff about health plan and care to be given during after school activities. I give my permission for the school nurse to contact my child's healthcare provider(s) regarding the above condition.

_____ _____ _____ _____

Parent/Guardian **Phone** **Date** **E-mail**

Nurse signature: _____ **Date:** _____