Seizure Medical Management Plan

School: _____ School Year: _____ Grade: _____

Student Name: _____ DOB: _____ Student #: _____

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

Seizure Information

Type of seizure: _____ICD-10: _____

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:

❒ Medication name: _____ Dosage/frequency: _____

❒ Medication name: _____ Dosage/frequency: _____

Reminder that 911 must be called when Emergency Medication is administered

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: _____

IHP -- *NIC -- 00035 Risk for Injury* *NOC-- Minimize student's risk of sustaining injuries at school and improve student's access to educational programming.*