

# 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-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:

- 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: \_\_\_\_\_