

Individualized Seizure Action and Nursing Care Plan for the 2015-2016 School Year

This student is being treated for a seizure disorder. The information provided below is intended to assist school personnel should a seizure occur during school hours.

The Following is to be Completed by the Parent

Student's Name _____ DOB _____ Age _____

Allergies _____ Significant Medical History _____

Date of last seizure _____ How long does a typical seizure last? _____

How often do seizures occur? _____

School _____ Grade _____ HR Teacher _____

Parent/Guardian _____ Phone _____

Parent/Guardian _____ Phone _____

The Following is to be Completed by the Medical Provider

Date of seizure diagnosis _____

Medical Diagnosis _____

Current medication(s) _____

Special considerations or safety precautions _____

Student Specific Seizure Emergency Plan Per Medical Provider

Call 911 and parent/guardian for seizure activity in this student for the following:

- Absence (petit mal) seizure lasting longer than _____ minutes
- Generalized Tonic Clonic (grand mal) seizure lasting longer than _____ minutes
- Cluster seizure activity _____ or more seizures in _____ hour
- Other seizure (indicate type) _____ lasting longer than _____ minutes
- Administer Diastat (write order here) _____

Basic Seizure First Aid

- Stay calm & note time seizure began
- Keep student safe
- Do not put anything in student's mouth
- Do not restrain
- Protect head
- Stay with student & watch breathing

Other considerations for student with seizure emergency at school:

- ✓ Complete Seizure Observation Form
(Send with EMS if possible)
- ✓ Notify School Nurse (RN)

Treating Physician _____ Phone _____ Fax _____

Physician Signature _____ Date _____

Parent Signature _____ Date _____

School Nurse Signature _____ Date _____

**LEON COUNTY SCHOOLS
AUTHORIZATION FOR MEDICATION OR TREATMENT**

(Use one form for each medication. This permission form is valid for the current school year only.)

I hereby certify that it is necessary for my child, _____ (first/last name)/ _____ (date of birth), to be given the medication or treatment listed below during the school day, including when s/he is away from school property on official school business. I hereby authorize the School Board of Leon County, Florida (LCSB), and Florida Department of Health in Leon County (DOHLC) and their officers, employees, contractors and agents to assist my child with medication administration and/or to supervise my child's self-administration of medication(s) as directed by his/her prescribing physician(s). I acknowledge and agree that non-health professionals, trained in medication administration, may assist my child with medication administration.

This form must be signed for all the following: medicines given by mouth, inhaled, by nebulizer, on skin, patch, injection, etc. **Only FDA-approved prescribed and over-the-counter medicines will be accepted.**

Name of medication: _____

Reason for medication (diagnosis): _____

Dosage to be given: _____ Route (mouth, injection, etc.): _____

Time(s) of administration: _____ Allergies: _____

Beginning date: _____ Ending Date: _____ Amount of liquid or count of pills: _____

Emergency telephone numbers:

Parent/Guardian: _____ H: _____ C: _____

Parent/Guardian: _____ H: _____ C: _____

Doctor's Name: _____ Doctor's Phone Number: _____

Prescription and over-the-counter medications/treatments shall come in original, labeled containers. Changes in medication times or dosage can only be made by written prescription from the physician, which may be faxed/scanned to school health personnel. Over-the-counter drugs/treatments shall **only** be administered up to **five calendar days** without a signed a licensed prescriber statement. A licensed prescriber must provide signed authorization for a student to self-carry or self-administer medications/treatments allowed by statute 1002.20 and LCSB policy (**see back of form**).

Parents are responsible for safe delivery of medication to the school (students may not transport medication unless authorized to self-carry emergency medications) and for picking up any leftover medication within ONE WEEK after the ending date. Medication left after this time will be discarded according to LCSB policy.

I hereby consent for the Leon County School District to disclose protected health information, as needed, to provide health services to my child. I understand this health information may be shared with the health care provider listed above, and I hereby authorize the exchange of this information. I also give permission for the information on this form to be utilized by the staff of this school and any school health personnel providing school health services in the district for the limited purpose of meeting my child's health and educational needs.

I hereby release, indemnify, and hold harmless LCSB, DOHLC and any of their officers, employees, contractors and agents any and all lawsuits, claims, demands, expenses, and actions against them associated with their activities assisting my child with medication administration and/or supervising my child's self-administration of medication(s), provided they follow the physician's orders on record. I also hereby agree to indemnify and hold LCSB, DOHLC and their officers, employees, contractors and agents harmless from any and all lawsuits, claims, demands, expenses, and actions against them arising from harm to any person caused by my child's actions with regards to a self-carried medication.

Date _____

Parent/Guardian Signature _____

Mission:
To protect, promote & improve the health
of all people in Florida through integrated
state, county & community efforts.



Rick Scott
Governor

John H. Armstrong, MD, FACS
State Surgeon General & Secretary

Vision: To be the Healthiest State in the Nation

Florida Department of Health in Leon County

CONSENT FOR SHARING OF PROTECTED HEALTH INFORMATION

School Year _____

Student's Name: _____

DOB: _____

School: _____

I hereby consent to health information being shared to carry out treatment or clarify medical orders in order to keep my child safe while at school. I understand that Registered Nurses from the Florida Department of Health in Leon County, School Health Division, may be giving and receiving information pertaining to the management of my child's medical condition with the following organizations:

(Please check *and* initial all that apply)

___ Leon County School District

___ Tallahassee Memorial Hospital Diabetes Center

___ Children's Medical Services

(Name of case manager: _____)

___ Florida Department of Health in Leon County (Health Department)

___ Tallahassee Pediatric Foundation

___ Primary Physician _____

(Please fill in Physician name)

___ Specialist Physician _____

(Please fill in Physician name)

I may request a notice of the complete description of such uses and disclosures prior to signing this consent.

I understand that I have the right to revoke this consent in writing.

Signature

Date

Florida Department of Health
School Health Division
Leon County Health Department
P.O. Box 2975 • Tallahassee, FL 32316
PHONE: 850/606-8150 • FAX 850/487-7954

www.FloridasHealth.com
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FACEBOOK: FLDepartmentofHealth
YOUTUBE: fldoh

