

Individualized Seizure Action and Nursing Care Plan for the _____ 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 _____

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