## 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______________________

# 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 inLeon 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 <u>all</u> that apply)**

___ [**X**] Leon County School District
___ [ ] Tallahassee Memorial Hospital Diabetes Center
___ [ ] Children's Medical Services
(Name of case manager: ________________________________)
___ [**X**] 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