Individualized Seizure Action Plan for the 20___ - 20___ 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 or Legal Guardian

Student's Name _____ DOB_____ Age _____
Allergies _____ Significant Medical History _____
Date of Last Seizure: _____ How long does a typical seizure last? _____
Symptoms: _____ How often do seizures occur? _____
Student's understanding of and ability to manage seizure disorder: _____
_____
School: _____ Grade Level: _____ Home Room: _____
Parent/Guardian Name: _____ Phone: _____
Parent/Guardian Name: _____ 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 <u>and</u> 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 Rescue Medicine as prescribed (write order here): _____
  Call 911 if Rescue Medicine is administered

<u>Basic Seizure First Aid</u>

- Stay calm & note time seizure began
- Call 911 if indicated above
- Keep student safe
- Do not put anything in student's mouth
- Do not restrain
- Protect head
- Stay with student & watch breathing

Other considerations for students with seizure emergency at school:

- ✓ Notify Parent/Guardian
- ✓ Complete Seizure Observation Form (send copy with EMS if possible)
- ✓ Print student demographic page from Focus and send with EMS
- ✓ Notify School Nurse (RN)

Treating Physician: _____ Phone: _____ Fax: _____

Physician Signature: _____ Date: _____

Parent/Guardian 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 she/he is away from school property on official school business. I hereby authorize the School Board of Leon Count, 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 the 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 for **five calendar days** without a signed 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.

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 from 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

Florida Department of Health, 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 <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
____ [ ] 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.

_____ _____

Parent/Guardian Signature Date