Seizure Medical Management Plan

Student ____ Date of Birth ________________

School ____Year_______Grade____________

Seizure Information

Type of Seizure ____

Description of seizure activity ____

Typical duration of seizure _______________________How often seizures occur ___________________

Triggers/warning signs____

Reactions after seizure____

Special Diet/Other pertinent information ____

Seizure Medication Management

Daily Medication	**Dose/Frequency**	**Given at School?**	**Time**

Student has VNS Magnet? Yes _____ No___

Directions for use:____

____

Emergency Medication ________________________________ **Dose**_________ **Route** __________

When to Give___________________________ **When to repeat dose**_________________________

For a seizure lasting longer than _____ minutes or_______________________________________

____**, CALL 911.**

This Seizure Medical Management Plan has been approved by:

Signature of Health Care Provider____________________________________ **Date** ___________

Phone ____________________ **Fax** _________________ **E-mail** ___________________________

For Parent /Guardian to complete

I have reviewed and give my permission to the school nurse, and other designated staff member(s) to perform and carry out the tasks as outlined by this Seizure Medical Management Plan for my child. I also consent to the release of information contained in this plan to all staff and other adults who may need to know this information to maintain my child's health and safety at school. I give my permission for the school nurse to contact my child's healthcare provider(s) regarding the above condition.

Parent/Guardian ____ Date________________

E-mail ____ Phone_____________ Cell: __________