

SCHOOL MANAGEMENT PLAN: SEIZURE DISORDER

Seizure Type(s): _____

SECTION I – Parent (Please Print)

Student Name: _____ DOB: _____ Weight: _____

Allergy to: _____ School: _____ Grade/Teacher: _____

Medications Taken At Home: _____

Transportation To and From School: _____ AM: _____ PM: _____

Parent Name _____ Cell Phone _____ Work Phone _____

Emergency Contact Name _____ Relationship to Student _____ Cell Phone _____ Work Phone _____

Physician: _____ Phone Number: _____

Preferred Hospital in Case of Emergency: _____

Do you have any Religious Objections to Medical Treatment: Yes No

If "yes", describe: _____

Section II - Physician

Does student experience an aura before seizures? No Yes If "Yes", describe: _____

Behavior or activity student usually exhibits during seizures: _____

School Plan: *A completed & signed authorization form required for each medication administered in school setting.

IF YOU SEE THIS...	DO THIS...
SEIZURE ACTIVITY: Student has VNS? <input type="checkbox"/> Yes → Swipe Magnet* (Refer to Order Form) <input type="checkbox"/> No *Emergency Medication ordered for school? <input type="checkbox"/> Yes <input type="checkbox"/> No *Administer after ___ minutes OR if ___ seizures in ___ minutes.	1. Remain with student, provide privacy, clear area, 2. If tonic/clonic seizure, place student in side-lying position, 3. Do not put anything in mouth or restrict student. Protect head. 4. Time duration of seizure. Document activity on Seizure Log. 5. Contact parent/emergency contact to inform him/her of seizure. 6. Contact parent &/or EMS if student unable to return to normal. activity following postictal period. Student will not remain at school.
	1. Administer emergency medication as prescribed. 2. *MEDICATION: _____ DOSAGE: _____ 3. Contact parent/emergency contact. EMS will treat per protocol.

Bus Rider Plan: *A completed & signed authorization form required for each medication administered in school setting.

IF YOU SEE THIS...	DO THIS...
Seizure activity is noted. *Emergency Medication ordered for bus ride? <input type="checkbox"/> Yes <input type="checkbox"/> No	1. Bus driver will pull over at first safe location and call/radio bus dispatcher. 2. Dispatcher will activate EMS and call parent or emergency contact. 3. Driver or aide will remain with student and provide privacy as possible. Place student on his/her side and do not restrain. Protect head. 4. Document time and specifics of seizure. Report same to EMS personnel. 1. If ordered for bus ride, administer emergency medication & activate EMS. 2. *MEDICATION: _____ DOSAGE: _____ 3. Contact parent/emergency contact. EMS will treat per protocol.

I UNDERSTAND AND AGREE WITH THIS MANAGEMENT PLAN:

I give permission for my child to be transported to the hospital indicated on this form, in the event of an emergency.

I give permission for the release of my child's medical information, in the event of an emergency.

Physician Signature Date

School Nurse Signature Date

Parent Signature Date

Staff Signature / Bus Driver Date

School Nurse Use Only

Medication	Expiration Date	Self-Carry?	Location of Medication and/or Magnet