ST. JOHNS COUNTY SCHOOL DISTRICT

Medical Management Plan SEIZURE DISORDER

SCHOOL YEAR: 2025-2026

Student Name: _____ Date of Birth: _____

Physician's Name: _____ Phone #: _____

Address: _____ Fax #: _____

List Known ALLERGIES: _____

Type of seizures: _____

Please list all medications (HOME & SCHOOL): _____

Are medications needed **during school hours**? ☐ Yes ☐ No

If yes, please list:

Name of medication	Prescribed Dose/Route	When to use

If Diastat or Midazolam is ordered, it should be given: ☐ At onset of seizure ☐ Minutes into seizure after ☐ Seizures in a row

Is VNS used? (if yes please instruct) ☐ Yes ☐ No _____

Are there activity limits? (if yes please describe) ☐ Yes ☐ No _____

Is protective equipment required? (if yes please describe) ☐ Yes ☐ No _____

Nursing services are recommended for the care of this student during the school day.

Physicians Signature: _____ **Date:** _____

For Parent to Complete:

1. When was the last seizure? _____
2. At what age did the seizure activity begin? _____
3. Describe the seizure? _____
4. How often do seizures occur? _____
5. How long do the seizures normally last? _____
6. Has the seizure ever lasted longer than 5 minutes? ☐ Yes ☐ No
   If yes, how was it handled? _____

Continued Seizure Plan for (Student NAME) _____

7. Does your child lose bowel or bladder control during a seizure? Yes ☐ No ☐
8. Has your child ever turned blue or stopped breathing during a seizure? Yes ☐ No ☐
   If yes, how was it handled?
9. Has your child ever required hospitalization due to a seizure Yes ☐ No ☐
   If yes, please explain:
10. Is there anything that seems to trigger a seizure? Yes ☐ No ☐
    If yes, please list:
11. Does your child experience an aura before a seizure? Yes ☐ No ☐
    If yes, please explain:

Other considerations that will assist the school in providing care for your child: _____

Is your child compliant with their current treatment regime? Yes ☐ No ☐

Does your child function independently with medication administration? Yes ☐ No ☐

Are there any activity restrictions for your child? Yes ☐ No ☐

If yes, please list: _____

PARENT/GUARDIAN to Complete: Authorization for Health Care Provider and School Nurse to Share Information

I authorize my child's school nurse to assess my child as it relates to his/her special health care needs and to discuss these needs with my child's physician as needed throughout the school year. I understand this is for the purpose of generating a health care plan for my child. I understand I may withdraw this authorization at any time and that this authorization must be renewed annually.

As the parent or guardian of the student named above, I request that the principal or principal's designee assist in the administration of medication/treatment prescribed for my child.

I understand that under provisions of Florida Statue 1006.062, there shall be no liability for civil damages as a result of the administration of medication when the person administrating such medication acts as an ordinarily reasonable, prudent person would have acted under the same or similar circumstances. I also grant permission for school personnel to contact the physician listed above if there are any questions or concerns about the medication. I have read the guidelines and agree to abide by them. I authorize the physician to release information about this condition to school personnel.

Parent/Guardian Signature	**Print Name**	**Date**

Parent/Guardian _____ Cell: _____

Work: _____

Parent/Guardian: _____ Cell: _____

Work: _____