Individualized Seizure Action Plan

Lee County School District

School Year 20_____ - 20_____

Student's Name: ______________________________ Student ID: ______________ DOB: ______________
Parent/Guardian: ______________________________ Phone ______________ Other: ______________
Emergency Contact: ______________________________ Phone: ______________ Other: ______________
Healthcare Provider: ______________________________ Phone: ______________ Fax: ______________

Medical Orders (Physician, PA, or APRN who manages student's seizure disorder- complete all sections below and sign)

Seizure History	
Date of onset:	Date of last known seizure:
Seizure type:	
Aura (If known):	Can the student identify aura: ☐ Yes ☐ No
Does the student understand their diagnosis? ☐Yes ☐ No	Is the student able to identify oncoming seizure activity? ☐ Yes ☐ No
Triggers (Describe all):	

Symptoms of Seizure/ Seizure Type	
☐ Generalized shaking	☐ Staring
☐ Loss of consciousness/awareness	☐ Stiffening
☐ Other:	

Seizure Management	
Emergency Medication: ☐ Nayzilam ☐ Diastat ☐ Valtoco ☐ Other:	
Dose: ☐ 5mg ☐ 7.5mg ☐ 10mg ☐ 15mg ☐ 20mg ☐ Other:	Route: ☐ Rectal ☐ Nasal
Administer at onset of seizure ☐ Yes ☐ No If *no,* then give for seizure lasting longer than ______ minutes after onset of seizure.	
Emergency medication administration instructions:	
Has the student taken this medication before? ☐ Yes ☐ No *If 1st time administration of medication, 911 will be called when given.	
Implanted Device Type: ☐ N/A ☐ VNS	Does the student know how to use implanted device? ☐ Yes ☐ No
VNS instructions (quantity of swipes and frequency): ☐ Swipe magnet to activate VNS at onset of seizure. ☐ Continue to swipe VNS with magnet every one minute during seizure.	
Precautions, possible side effects for recommended intervention: ☐ Monitor breathing Other:	
Call 911 for the following:	
On onset of seizure ☐ Yes ☐ No	If 1st time administration of medication, 911 will be called when given.
Call 911 at ______ minutes after onset of seizure or at_______ minutes after emergency medication is given, if seizure activity still present. Other instructions:	
Call Student's Health Care Team for the following: ☐ Any seizure activity ☐ If atypical seizure activity ☐ Emergency medication administration ☐ Other:	
Call Parent/guardian/emergency contact for the following: ☐ Any seizure activity ☐ If atypical seizure activity ☐ Emergency medication administration ☐ Other:	

Student's Name:______________________________ Student's DOB: __________________ Student's ID: ______________________

Accommodations / Special Considerations: If YES please indicate accommodation(s) or restrictions needed
Does the student need accommodations in the classroom setting? ☐ Yes ☐ No Needed accommodations:
Can the student participate in PE/Recess? ☐ Yes ☐ No Needed accommodations:
Can the student participate in school activities? ☐ Yes ☐ No Needed accommodations:
Does the student need transportation accommodations? ☐ Yes ☐ No Needed accommodations: *Emergency medication is not given on the school bus. 911 will be called at onset of seizure.
Can the student participate in after school programming? ☐ Yes ☐ No Needed accommodations:
Can the student participate in field trips? ☐ Yes ☐ No Needed accommodations:

The medical professional who is completing this document should provide in this section additional medical orders not covered on this form:

Physician's/Mid-Level Practitioner's[1] Name: ____

Physician's/Mid-Level Practitioner's[1] Signature: ________________________________ **Date:** ______________

Office Address: ____

Phone: ________________________________ **Fax:** ______________________

Place Office Stamp Here

Florida Statute 1006.062 requires written parental consent for a student to take medication during the school day.

The Student's Healthcare plan will be developed in accordance with these orders. The plan will be distributed to the Educational Staff and school nurse.

I agree with the above prescribed medication regimen, treatment, or procedure, and authorize the personnel of The School District of Lee County, who have been trained by the school nurse, to administer medication to my child/student. I understand that these persons are unlicensed assistive personnel. It is understood that this medication will be administered, if needed, on field trips. I release the School Board and any of its employees from all claims, demands, damages, actions, causes of action, or suits at law or in equity, of whatsoever nature against the School Board and any of its employees for administering said treatment/procedure. I also authorize the school nurse to contact the prescribing licensed health care provider or his/her designee to exchange information concerning the purpose, dosage, and effects of this medication. I understand that all supplies are to be furnished/restocked by parents(s)/guardian(s).

Student's Name: ______________________ **Student's DOB:**__________________ **Student's ID:**______________

Parent/Guardian Signature: ____ **Date:** ________________

School Health Registered Nurse Signature: ________________________________ **Date:** ________________

[1] In accordance with 1006.0626, FL Stat., this form must be executed by a Physician or Physician Assistant (licensed under Chap. 458 or 459, FL Stat.), or an Advanced Practiced Registered Nurse (licensed under Section 464.012, FL Stat. and who provides epilepsy or seizure disorder care to the student).