Bay District Schools
Seizure Management Plan for School Year 2021-2022

Student Name:	DOB:	Student ID:	Grade:
Parent/Guardian #1:	Cell #:	Home #:	Work #:
Parent/Guardian #2:	Cell #:	Home #:	Work #:
Healthcare Provider:	Phone #:	Fax #:	
Preferred Hospital:			
Allergies ☐Yes ☐No -- If yes list allergies:			

I. ACTION PLAN -- To be completed by Physician:

Diagnosis/Condition for which drug is to be given: _____ Seizure Type: _____

Medications Prescribed: _____

Medication Prescribed for School: _____

Route of Administration: _____ **Dosage Amount:**_____

Frequency/Time(s) to be administered: _____

Note any possible side effects: _____

Is the medication a controlled substance? ☐ Yes ☐ No Date to be discontinued (if applicable): _____

Medical Treatment Prescribed (Initial if Applicable)

_____ Vagal Nerve Stimulator: Swipe with magnet at the onset of seizure. May repeat every _____minutes as needed.
Student allowed to carry VNS on person while in school ☐ Yes ☐ No
If "yes", I hereby affirm this student has been instructed on the proper self-administration of the VNS magnet. ☐ Yes ☐ No

_____ Diastat _____mg: Administer rectally: ☐at onset of seizure **OR** ☐_____

_____ Single Dose Nasal Spray (Nayzilam/Valtoco) _____mg: Administer intranasal to one nostril ☐at onset of seizure
OR ☐_____

Action Plan for Seizure Management:

- Confirm seizure, note time began, notify school staff, activate 911, if applicable.
- Provide first aid.
- Gather, prepare, and administer rescue medication or VNS magnet, if prescribed.
- **Seizure events requiring no 911 response:** After seizure allow student to rest until able to return to class or parent arrives to take home.

- **For 911 calls:** The administration of Diastat or intranasal spray, seizures > _____ minutes, and back-to- back seizures; stay with student, monitor seizure activity, and continue to monitor ABC's until EMS arrives.
Initiate CPR, if indicated.

Name of Physician: _____ Physician's Telephone: _____ Fax: _____

Physician's Signature: _____ Date: _____

Revised 7/13/2021

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II. PARENTAL PERMISSION --To Be Completed by Parent/Guardian

I hereby authorize the above-named Healthcare Provider and Bay District Schools, Charter Schools, and PanCare of Florida, Inc. staff to reciprocally release verbal, written, faxed, or electronic student health information regarding the above-named child for giving necessary medication or treatment while at school. I understand Bay District Schools, Charter Schools, and PanCare protect and secure the privacy of student health and education information as required by federal and state law and in all forms of records, including, but not limited to, those that are oral, written, faxed or electronic. I request that my child be assisted in taking the medication or treatment described above at school by authorized persons as permitted by me and my physician. I understand that all procedures will be implemented in accordance with Florida state law and regulations and may be performed by unlicensed designated school personnel (FL Statute 1006.062) under the training provided by the school nurse.

It is understood there shall be no liability for civil damages as a result of the administration of the medication when the person administering the medication acts as an ordinarily reasonably prudent person would have acted under the same or similar circumstances. All medication **MUST** be brought to the school by a responsible adult in the original container. If possible, the first dose of any of any new seizure medication should be given in a controlled medical environment. Medication orders **MUST** be renewed by the attending physician and this release signed by the parent or guardian at the beginning of each school year.

Parent/Guardian Signature: _____ Date: _____ Phone: _____