Seizure Medical Management Plan

Albuquerque Public Schools **School: ___________________________________ School Year: ________________ Grade: ______**

Student Name: ____ DOB: _______________ Student #: ________________

Provider Name: ____ Phone #: _____________________ Fax #: ___________

Seizure Information

Type of seizure: ____ICD-10: __________________

Description of student's seizure activity:____

How often do the seizures occur: ____

Typical duration: ____ Date of last seizure:______________________________

Seizure triggers or warning signs: ____

Student's reaction/behaviors after seizure: ____

Dietary Restrictions: ❒Not applicable or ❒Special Diet____

Activity Restrictions: ❒None or ❒Special Instructions____

Routine Seizure Management

Routine Medications:

❒ Not applicable

❒ Medication name: ___________________________ Dosage/frequency: ________________Given at school: Y N Time:______________

Instructions:____

❒ Medication name:____________________________ Dosage/frequency: _______________Given at school: Y N Time:______________

Instructions:____

VNS:

❒This student has Vagal Nerve Stimulator (VNS). Use as follows____

____

Emergency Management

For seizures lasting greater than ______minutes OR _________or more seizures in _________hours, CALL 911 and/or refer to Emergency Medication orders below.

Emergency Medications:

❒ Diastat: Dosage/frequency: ____

911 will be called when Diastat is administered

❒ Other: Name ____ Dosage/frequency :____________________________________

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SIGNATURES: This Seizure Medical Management Plan has been approved by:

___________________________________ ________________ ____

Healthcare Provider **Date** **E-mail**

I give my permission to the school, school nurse, licensed/unlicensed assistive personnel, and other designated staff member(s) to perform and carry out the care tasks as outlined by this Seizure Medical Management Plan for my child, and I acknowledge that I have received a copy of the signed plan. I also consent to the release of the information contained in this plan to all staff and other adults who have custodial care of my child and who may need to know this information to maintain my child's health and safety. I will notify extra-curricular staff about health plan and care to be given during after school activities. I give my permission for the school nurse to contact my child's healthcare provider(s) regarding the above condition.

____________________________ __________________ __________________ ______________________________

Parent/Guardian **Phone** **Date** **E-mail**

Nurse signature: ____ **Date: ____________________**