Pasco County Schools

Seizure Medical Management Plan

Student Name:	D.O.B:	School Year:
Diagnosis:		
Medication(s):		

Seizure Information

Indicate type of seizure disorder

☐ Tonic – Clonic ☐ Myoclonic Other

☐ Simple Partial ☐ Atonic

☐ Complex Partial ☐ Absence

Seizure History

Date of onset Last Known Seizure

Seizure triggers: ☐ TV/Video games ☐ Computer monitor ☐ Fire alarm/strobe light

Aura (if known)

Emergency Medication for Seizure

Administer medication as directed below for seizures lasting more than minutes.

Medication:

Dose: Route:

☐ **If seizure continues after giving emergency medication, call 911.**

Special Instructions:

List any Special Considerations or Precautions regarding sports, school activities and/or field trips:

Parent has provided emergency medication to school: ☐ YES ☐ NO

Print, type, or stamp Physician's Name & Information: _____

Address: _____ Phone: _____ Fax: _____

Physician Signature: _____ Date: _____

Parent Signature: _____ Date: _____

School Nurse Signature: _____ Date: _____

I hereby authorize the above named physician and Pasco County Schools staff to reciprocally release verbal, written, faxed, or electronic student health information regarding the above named child for the purpose of giving necessary medication or treatment while at school. I understand Pasco County Schools protects and secures the privacy of student health 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 hereby authorize and direct that my child's medication or treatment be administered in the manner set forth in this medical management plan. I understand that all supplies are to be furnished/restocked by parent.