Pasco County Schools

Individualized Seizure Action Plan for School Year 20____ - 20____

Student's Name: ______	Student ID: _____	DOB: _____	Diagnosis: _____
School: _____	Grade: _____	Home Room: _____	
Parent/Guardian #1: _____	Home #: _____	Cell #: _____	Work #: _____
Parent/Guardian #2: _____	Home #: _____	Cell #: _____	Work #: _____
Parent/Guardian's E-mail Address: _____	Preferred Communication Method: ☐ Phone ☐ Email		
Healthcare Provider: _____	Phone: _____	Fax: _____	

Medical Orders (MD, PA, or ARNP 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 Student Identify Aura: ☐ No ☐ Yes
Does the student understand his/her diagnosis? ☐ No ☐ Yes	Is the student able to identify oncoming seizure activity? ☐ No ☐ Yes
Triggers:	☐ Electronics (Type: ______ ☐ Fire Alarm/Strobe Light ☐ Anxiety/Startling ☐ Illness ☐ Sleep Deprivation ☐ Specific Time of Day/Night: ______ ☐ Nutrional Factors: ______ ☐ Other: ______

Symptoms of Seizure	
☐ Staring	☐ Loss of Bower/Bladder Control
☐ Jerking Movement of Arms and Legs	☐ Not Responding to Noise or Words for Brief Periods
☐ Stiffening of the body	☐ Appearing Confused or in a Haze
☐ Breathing difficulties	☐ Nodding Head Rhythmically (Associated with loss of awareness or consciousness)
☐ Loss of Consciousness	☐ Having sudden rapid eye movements
☐ Falling Suddenly	☐ Other: ______

Seizure Management			
Emergency Medication: ______	Dose: ______	Route: ______	Administer for seizure lasting longer than ______ minutes.
Emergency Medication: ______	Dose: ______	Route: ______	Administer for seizure lasting longer than ______ minutes.
Daily Medication: ______	Dose: ______	Route: ______	Time of Day: ______
Emergency Medication will be provided by parent: ☐ No ☐ Yes			
Implanted Device Type: ☐ N/A ☐ VNS	**Does the student know how to use implanted device?** ☐ No ☐ Yes		
VNS instructions (quantity of swipes and frequency): ______			

Call 911 for the following:
☐ If seizure continues after giving emergency medication
☐ On onset of seizure
☐ If atypical seizure activity
☐ Other: ______

Call Parent/guardian/emergency contact for the following:______

Emergency Contact:______

Student's Name: ______________________ **Student's DOB: ____________** **Student's ID#____________**

Accommodations / Special Considerations: If yes please indicate accommodation(s) or restrictions needed
Is the student allowed to participate in sports? ☐ No ☐ Yes
If yes are there any restrictions? ☐ No ☐ Yes Restrictions:
Any restrictions/Accommodations needed for the following? Classroom Setting: ☐ No ☐ Yes: _____ Recess: ☐ No ☐ Yes: ______ School Activities: ☐ No ☐ Yes: ______ Transportation: ☐ No ☐ Yes: _____ After school programming: ☐ No ☐ Yes: ______ Field Trips: ☐ No ☐ Yes: ______

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

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

I hereby authorize the above-named physician and Pasco County School's 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 protect and secure 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 parents(s)/guardian.
I acknowledge that I am the parent/guardian of the student listed above and I have the rights and authority set forth in the Parent's Bill of Rights and related laws, and I further acknowledge that I have had the opportunity to review the district's resources identifying my rights (including the notices located at https://www.pasco.k12.fl.us/ssps/page/parent_notices, and pursuant the Parent's Bill of Rights, Chap.1014, Fl. Stat.), and my acknowledgement and my consent is indicated by my signature below. I understand that the form must be completed upon entry into school and at the beginning of each school year.

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).