Individualized Seizure Action Plan
The School District of Lee County
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 Information	
Date of onset:	Date of last known seizure:
Seizure type:	
Symptoms of seizure: ☐ Generalized shaking ☐ Staring ☐ Stiffening ☐ Loss of consciousness/awareness ☐ Other:	
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):	

Seizure Management	
Emergency Medication: ☐ Nayzilam ☐ Diastat ☐ Valtoco ☐ Other:	
Dose: ☐ 5mg ☐ 7.5mg ☐ 10mg ☐ 15mg ☐ 20mg ☐ Other:	Route: ☐ Rectal ☐ Nasal
Has the student taken this medication before? ☐ Yes ☐ No * If 1st time administration of medication, 911 when be called when given.	
Administer for seizure lasting longer than _____ minutes.	
Emergency medication administration instructions (include cluster, #, or length):	
Implanted Device Type: ☐ VNS ☐ Other:	Does the student know how to use the implanted device? ☐ Yes ☐ No
Implanted device instructions (quantity of swipes and frequency):	
Precautions and/or possible side effects for recommended intervention:	
When to call 911: ☐ Onset of seizure ☐ Atypical seizure activity ☐ At _____ minutes after onset of seizure ☐ At _____ minutes after emergency medication is given, if seizure activity is still present ☐ Other:	
Call Student's Health Care Team for the following: ☐ Any seizure activity ☐ Atypical seizure activity ☐ Emergency medication administration ☐ Other:	
Call Parent/guardian/emergency contact for the following: ☐ Any seizure activity ☐ Atypical seizure activity ☐ At _____ minutes after onset of seizure ☐ Emergency medication administration ☐ Other:	

Student's Name: _____ Student's DOB: _____ Student's ID#_____

Accommodations / Special Considerations

Any accommodations the student requires for school trips, after-school programs and activities, class parties, and any other school-related activities? ☐ No ☐ Yes

If yes, please indicate accommodation(s) or restrictions needed:

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 Name and Signature: _____ Date: _____

School Health Registered Nurse Name and 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).