District School Board of Pasco County

Seizure Medical Management Plan

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

Seizure Information

Indicate type of seizure disorder:
Tonic-clonic (convulsive)_____
Seizure clustering _____
Other _____

Student History

Date of onset _____

Last Known Seizure _____

Describe Aura if known: _____

Basic Seizure First Aid

- Keep student safe; do not restrain
- Protect head
- Turn on side
- **DO NOT** place anything in mouth
- Stay with child until fully conscious
- Note time and record event

Emergency Medication for Seizure **(to be completed by physician)**

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

Medication: Dose: Route:	**Call 911 after giving medication if seizure continues.** **Notify Emergency Contacts and School Administrator.** Special Instructions:

List any Special Considerations or Precautions (regarding sports, school activities, field trips):

Physician Signature:_____ Date: _____

Parent Signature:_____ Date: _____

REV 5/11