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.

Pasco County Schools
General Guidelines for Administration of Medication at School

I have read Pasco County Schools' *General Guidelines for Administration of Medication at School* and permission is hereby granted to _____ Pasco County Schools'
(Name of school)
trained personnel to administer the following medication to:

_____
(Student's name) (Student #) (Grade) (DOB)

for the treatment of _____.
(Health condition)

Name of prescribing Health Care Provider: _____

Known Allergies: _____

Name of medication: _____

Dose of medication: _____ Route of medication: _____ Time to be given at school: _____

Special instructions (including reasons for which medication must be administered during the school day or at after school activities): _____

_____

Possible reactions / side effects: _____

_____

I hereby authorize designated 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 authorization form. I understand that I am responsible to furnish/restock all supplies and medications and that any unused medication that is not retrieved by me at the end of the school year will be destroyed.

_____ Date: _____
(Signature of Parent / Guardian)

Note: Give parent copy of *General Guidelines for Administration of Medication at School*