CLAY COUNTY SCHOOL DISTRICT
FLORIDA DEPARTMENT OF HEALTH - CLAY COUNTY
SCHOOL HEALTH SERVICES
2016-2017

SEIZURE MEDICAL MANAGEMENT PLAN

(Must be filled out completely by Physician/Healthcare Provider)

OPJ Clinic Fax
904-278-2009

Student Name: _____ DOB: _____

Parent / Guardian: _____ Phone: _____

Physician / Provider: _____ Phone: _____

Allergies: _____

SEIZURE INFORMATION

Type: _____

Frequency/Length: _____

Triggers: _____

Warning Signs/Aura: _____

Date of last seizure: _____

MANAGEMENT

Medications at home: ☐ Yes (If yes, please specify): _____
☐ No

Medications at School: ☐ Yes (If yes, please specify): _____
☐ No

Special Considerations and Precautions (regarding school activities, sports, field trips, helmet use, etc.):

_____

Limitations: ☐ Cleared without limitation including all PE, physical activity, and recess.
☐ **NOT CLEARED** for _____

SEIZURE EMERGENCY MANAGEMENT

Does the student have Diastat at school? ☐ Yes ☐ No Dosage: _____

Does the student have a Vagus Nerve Stimulator? ☐ Yes ☐ No

Directions for use of magnet: _____ Swipes at onset of seizure, _____ minutes between swipes,
_____ Swipes before any emergency medication

GIVE DIASTAT

☐ For seizures lasting longer than _____ minutes.
☐ For multiple seizures > _____seizures in one hour.

CALL 911

☐ If seizures do not stop _____ minutes after giving emergency medication.
☐ If still seizing after _____ swipes of magnet.
☐ If student has any breathing difficulty during seizure.

_____ _____
Physician/Provider Signature (Required) **Date**

_____ _____
School Nurse Signature **Date**

OFFICE STAMP

Revised 4/2016