



PERSONAL | PASSIONATE
PROGRESSIVE

Individualized Seizure Action Plan

Lee County School District

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 History

Date of onset:	Date of last known seizure:
Seizure type:	
Aura (If known):	Can the student identify aura: <input type="checkbox"/> Yes <input type="checkbox"/> No
Does the student understand their diagnosis? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is the student able to identify oncoming seizure activity? <input type="checkbox"/> Yes <input type="checkbox"/> No
Triggers (Describe all):	

Symptoms of Seizure/ Seizure Type

<input type="checkbox"/> Generalized shaking	<input type="checkbox"/> Staring
<input type="checkbox"/> Loss of consciousness/awareness	<input type="checkbox"/> Stiffening
<input type="checkbox"/> Other:	

Seizure Management

Emergency Medication: <input type="checkbox"/> Nayzilam <input type="checkbox"/> Diastat <input type="checkbox"/> Valtoco <input type="checkbox"/> Other:	
Dose: <input type="checkbox"/> 5mg <input type="checkbox"/> 7.5mg <input type="checkbox"/> 10mg <input type="checkbox"/> 15mg <input type="checkbox"/> 20mg <input type="checkbox"/> Other:	Route: <input type="checkbox"/> Rectal <input type="checkbox"/> Nasal
Administer at onset of seizure <input type="checkbox"/> Yes <input type="checkbox"/> No If <i>no</i> , then give for seizure lasting longer than _____ minutes after onset of seizure.	
Emergency medication administration instructions:	
Has the student taken this medication before? <input type="checkbox"/> Yes <input type="checkbox"/> No *If 1 st time administration of medication, 911 will be called when given.	
Implanted Device Type: <input type="checkbox"/> N/A <input type="checkbox"/> VNS	Does the student know how to use implanted device? <input type="checkbox"/> Yes <input type="checkbox"/> No
VNS instructions (quantity of swipes and frequency): <input type="checkbox"/> Swipe magnet to activate VNS at onset of seizure. <input type="checkbox"/> Continue to swipe VNS with magnet every one minute during seizure.	
Precautions, possible side effects for recommended intervention: <input type="checkbox"/> Monitor breathing Other:	
Call 911 for the following:	
On onset of seizure <input type="checkbox"/> Yes <input type="checkbox"/> No	If 1 st time administration of medication, 911 will be called when given.
Call 911 at _____ minutes after onset of seizure or at _____ minutes after emergency medication is given, if seizure activity still present. Other instructions:	
Call Student's Health Care Team for the following: <input type="checkbox"/> Any seizure activity <input type="checkbox"/> If atypical seizure activity <input type="checkbox"/> Emergency medication administration <input type="checkbox"/> Other:	
Call Parent/guardian/emergency contact for the following: <input type="checkbox"/> Any seizure activity <input type="checkbox"/> If atypical seizure activity <input type="checkbox"/> Emergency medication administration <input type="checkbox"/> Other:	

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

Accommodations / Special Considerations: If YES please indicate accommodation(s) or restrictions needed

Does the student need accommodations in the classroom setting? ☐ Yes ☐ No
 Needed accommodations:

Can the student participate in PE/Recess? ☐ Yes ☐ No
 Needed accommodations:

Can the student participate in school activities? ☐ Yes ☐ No
 Needed accommodations:

Does the student need transportation accommodations? ☐ Yes ☐ No
 Needed accommodations:

*Emergency medication is not given on the school bus. 911 will be called at onset of seizure.

Can the student participate in after school programming? ☐ Yes ☐ No
 Needed accommodations:

Can the student participate in field trips? ☐ Yes ☐ No
 Needed accommodations:

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's¹ Name: _____

Physician's/Mid-Level Practitioner's¹ 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 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).