ST JOHNS CLASSICAL ACADEMY

School Health Services

School Year _____

SEIZURE MEDICAL MANAGEMENT PLAN / EMERGENCY ACTION PLAN

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

Scholar Name: _____ DOB: _____

Parent / Guardian: _____ Phone: _____

Physician / Provider: _____ Phone: _____

Allergies: _____

SEIZURE INFORMATION: Type: _____ Frequency/Length: _____

Triggers: _____

Warning Signs/Aura: _____ Date of Last Seizure: _____

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

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

MANAGEMENT:

- Protect from Injury
- Do not insert anything into mouth
- Turn scholar on his/her side
- Monitor for type/duration of seizure & record
- Call Parents

● **Call 911 if:**
☐ Seizure lasts > ____ minutes after giving emergency medication
☐ Rapid sequence of seizures / loses consciousness
☐ Difficulty Breathing during or after seizure
☐ 1st time having seizure / Pregnant / Diabetic / Occurs in water
☐ If Diastat is administered, per school policy

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 scholar have Diastat at school? ☐ Yes ☐ No Dosage: _____

Does the scholar 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.

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

_____ _____
Parent/Guardian Signature (Required) **Date**

_____ _____
School Nurse Signature(Required) **Date**

OFFICE STAMP

Copies Given to:

☐ Parent ☐ Teacher ☐ 1st ☐ 2nd ☐ 3rd ☐ 4th ☐ 5th ☐ 6th ☐ 7th ☐ 8th ☐ 9-12th ☐ ESE ☐ Foreign L. ☐ Cafeteria
☐ Coach ☐ Music ☐ Art ☐ PE ☐ Other: _____