



Pasco County Schools  
**Individualized Seizure Action Plan for School Year 20\_\_\_\_\_ - 20\_\_\_\_\_**

Student's Name: _____	Student ID: _____	DOB: _____	Diagnosis: _____
School: _____	Grade: _____	Home Room: _____	
Parent/Guardian #1: _____	Home #: _____	Cell #: _____	Work #: _____
Parent/Guardian #2: _____	Home #: _____	Cell #: _____	Work #: _____
Parent/Guardian's E-mail Address: _____	Preferred Communication Method: <input type="checkbox"/> Phone <input type="checkbox"/> Email		
Healthcare Provider: _____	Phone: _____	Fax: _____	

**Medical Orders (MD, PA, or ARNP 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 Student Identify Aura:  No  Yes

Does the student understand his/her diagnosis?  No  Yes    Is the student able to identify oncoming seizure activity?  No  Yes

Triggers:

- Electronics (Type: \_\_\_\_\_)
- Fire Alarm/Strobe Light
- Anxiety/Startling
- Illness
- Sleep Deprivation
- Specific Time of Day/Night: \_\_\_\_\_
- Nutritional Factors: \_\_\_\_\_
- Other: \_\_\_\_\_

**Symptoms of Seizure**

<input type="checkbox"/> Staring	<input type="checkbox"/> Loss of Bower/Bladder Control
<input type="checkbox"/> Jerking Movement of Arms and Legs	<input type="checkbox"/> Not Responding to Noise or Words for Brief Periods
<input type="checkbox"/> Stiffening of the body	<input type="checkbox"/> Appearing Confused or in a Haze
<input type="checkbox"/> Breathing difficulties	<input type="checkbox"/> Nodding Head Rhythmically (Associated with loss of awareness or consciousness)
<input type="checkbox"/> Loss of Consciousness	<input type="checkbox"/> Having sudden rapid eye movements
<input type="checkbox"/> Falling Suddenly	<input type="checkbox"/> Other: _____

**Seizure Management**

Emergency Medication: _____	Dose: _____	Route: _____	Administer for seizure lasting longer than _____ minutes.
Emergency Medication: _____	Dose: _____	Route: _____	Administer for seizure lasting longer than _____ minutes.
Daily Medication: _____	Dose: _____	Route: _____	Time of Day: _____

Emergency Medication will be provided by parent:  No  Yes

Implanted Device Type:  N/A  VNS    Does the student know how to use implanted device?  No  Yes

VNS instructions (quantity of swipes and frequency): \_\_\_\_\_

Call 911 for the following:

- If seizure continues after giving emergency medication
- On onset of seizure
- If atypical seizure activity
- Other: \_\_\_\_\_

Call Parent/guardian/emergency contact for the following: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Student's Name: \_\_\_\_\_

Student's DOB: \_\_\_\_\_

Student's ID# \_\_\_\_\_

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

Is the student allowed to participate in sports?  No  Yes

If yes are there any restrictions?  No  Yes Restrictions: \_\_\_\_\_

Any restrictions/Accommodations needed for the following?

Classroom Setting:  No  Yes: \_\_\_\_\_

Recess:  No  Yes: \_\_\_\_\_

School Activities:  No  Yes: \_\_\_\_\_

Transportation:  No  Yes: \_\_\_\_\_

After school programming:  No  Yes: \_\_\_\_\_

Field Trips:  No  Yes: \_\_\_\_\_

The medical professional who is completing this document should provide in this section additional medical orders not covered on this form:

Empty box for additional medical orders.

Physician's/Mid-Level Practitioner's<sup>1</sup> Signature: \_\_\_\_\_

Date: \_\_\_\_\_



I hereby authorize the above-named physician and Pasco County School's 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 protect and secure 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 parents(s)/guardian.

I acknowledge that I am the parent/guardian of the student listed above and I have the rights and authority set forth in the Parent's Bill of Rights and related laws, and I further acknowledge that I have had the opportunity to review the district's resources identifying my rights (including the notices located at [https://www.pasco.k12.fl.us/ssps/page/parent\\_notices](https://www.pasco.k12.fl.us/ssps/page/parent_notices), and pursuant to the Parent's Bill of Rights, Chap.1014, Fl. Stat.), and my acknowledgement and my consent is indicated by my signature below. I understand that the form must be completed upon entry into school and at the beginning of each school year.

Parent/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

School Health Registered Nurse Signature: \_\_\_\_\_

Date: \_\_\_\_\_

<sup>1</sup> 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).