

ST. JOHNS COUNTY SCHOOL DISTRICT
HEALTH SERVICES

SEIZURE DISORDER MEDICAL MANAGEMENT PLAN
SCHOOL YEAR _____

Student Name: _____ Date of Birth: _____

Physician's Name: _____ Phone #: _____
(Please Print) Fax #: _____

Nursing services are recommended for the care of this student during the school day.
Please list all medications taken at home and school:

Are medications needed **during school hours**? Yes No

If yes, please list:

Name of Medication	Amount/Dose	When to use

If Diastat is ordered, it should be given at onset of seizure _____ minutes into seizure after _____ seizures in a row

Is VNS used? Yes No If yes, please instruct: _____

Are there activity limitations? Yes No If yes, please describe: _____

Is protective equipment required? Yes No If yes, please describe: _____

Physician's Signature _____ Date _____

For Parent to Complete:

1. When was the last seizure? _____

2. What type of seizures does your child have? _____

3. At what age did seizure activity begin? _____

4. Describe the seizure: _____

5. How often do seizures occur? _____

6. How long do the seizures normally last? _____

