Individualized Seizure Action Plan

This form is to be filled out and signed by a physician (medical doctor). If there is additional information regarding your child's seizure needs that do not fit on this document, all additional pages must be submitted on the physician's letterhead and each page signed by the physician. Please submit the care plan and the medication authorization form also completed by a physician, to studenthealth@flvs.net.

All documents are required for the care plan to be put in place.

Student Name: DOB: Student ID: Grade:

Parent/Guardian: Phone:

Other Emergency Contact: Phone:

Part to be completed by a Physician:

Physician Name: Date: Phone:

Allergies:

Seizure Information	
Seizure Type:	
How long it lasts:	
How often:	
What happens:	
Triggers:	

When rescue therapy may be needed:	
If seizure length, number or cluster:	
Name of medication:	
Medication dose:	
How to give:	
If seizure length, number or cluster:	
Name of medication:	
Medication dose:	
How to give:	

If seizure length, number or cluster:	
Name of medication:	
Medication dose:	
How to give:	

Care after a seizure:	
Describe care the student may need:	
When can the student return to normal activities:	
Special instructions: **For EMS or emergency department**	
Other:	

Responding to a seizure
First Aid: ● Stay calm and remain with the student.Notify registered nurse or trained staff ● Begin timing the seizure. ● Have another staff member call emergency contacts. ● Ensure the environment is safe by removing harmful objects. Don't restrain, protect the head. ● Assist the student on their side and keep the airway clear. ● Stay with the student until they have recovered from the seizure. ● Give rescue therapy if indicated by the ISAP

WHEN TO CALL 911
Seizure with loss of consciousness **longer than 5 minutes**, **not responding to rescue med** if available. **Repeated seizures longer than 10 minutes**, **no recovery** between them, not responding to rescue med if available. **Difficulty breathing** after seizure. **Serious injury** occurs or suspected, **seizure in water**.

Other information:	
Important medical history:	
Device: **EX: VNS RNS DBS**	
Special instructions:	

Physician Signature: Physician Stamp:

I certify that I am the parent or guardian of the above-named student, I approve this emergency care plan and understand that this plan will be shared with necessary Florida Virtual School ("FLVS"), state testing site personnel, county health department, medical personnel, and their employees and volunteers to ensure the safety of the student with a health condition. I authorize the above-medication to be administered as described or prescribed during FLVS in-person events or state testing. With full understanding of the risks involved, on behalf of myself and my child, I hereby release, hold harmless and indemnify FLVS, state testing site personnel, county health department, medical personnel, and their employees and volunteers for damages, payments, fees, and any other monetary obligations and indebtedness of any form caused by or arising from my child's personal injury or death arising from my child's self-administration of medication. I agree that I am responsible for providing the school with my emergency contact information, and my child's Emergency Care Plan, medication, and Medication Authorization form completed by the physician. By signing this form, I acknowledge that I have read and understand this form in its entirety.

Parent/Guardian Signature: _____ Date: _____