THE SCHOOL DISTRICT OF ESCAMBIA COUNTY
Health Services
30 E. Texar Dr., Pensacola, FL 32503
Phone: 469-5456

AUTHORIZATION FOR SEIZURE MANAGEMENT

THIS FORM IS VOID IF ALTERED IN ANY WAY

INSTRUCTIONS: Each of the three sections must be completed by the appropriate person as follows: Parts I and III by Parent/Guardian, Part II by Physician. Please return the completed form to the school clinic.

I. STUDENT INFORMATION (To Be Completed By Parent/Guardian).

Student's Name (Last, First, Middle)	Birth Date	Medicaid #	Grade//Homeroom Teacher

Parent/Guardian	Address

Home Phone	Work Phone	Other Phone (Cellular, Beeper, etc.)

Number of Hospitalizations for Seizures	Date of Last Hospitalization for Seizure

II. ACTION PLAN (To Be Completed by Physician). Please complete all spaces.

Diagnosis: SEIZURE DISORDER - This request is to be effective for the school year 20____ - 20____ OR Earlier Stop Date:

Medical Treatment Prescribed (Initial If Applicable):

_____ Vagal Nerve Stimulator: Swipe with magnet at time of initial evaluation. May repeat every 2 minutes as needed.

_____ Diastat 5mg — 10mg — 15mg — 20mg : Administer rectally for persistent convulsive seizure at 5 minutes **OR** for repetitive convulsive seizures
(Circle Dosage)

Action Plan for Seizure Management

Green Zone Seizure ≤ 2 minutes	Yellow Zone Seizure 2-5 minutes	Red Zone Seizure ≥ 5 minutes **OR** repetitive
• Begin first aid • Swipe Vagal Nerve Stimulator with magnet, if ordered • After seizure allow student to rest • Notify parent and return to class or home as appropriate	• Continue first aid • Prepare to administer Diastat, if ordered • After seizure allow student to rest • Notify parent and return to class or home as appropriate	• Call 911 • Administer Diastat, if ordered • Notify parent/guardian • Monitor respiratory status and continue first aid

Print Physician's Name	Physician's Address	Phone

Physician's Signature: _____ Date: _____

III. PARENTAL PERMISSION (To Be Completed By Parent/Guardian). Form is void if this section is incomplete.

I hereby request the school personnel, or its agents, to assist in the seizure management procedure for my child as prescribed by the doctor. I understand that there is no liability on the part of the school district, its personnel, or agents, including Escambia County Health Department personnel, for civil damages as a result of assisting with this procedure when the person acts as an ordinarily reasonably prudent person would have acted under the same or similar circumstances. I hereby authorize the exchange of medical information regarding my child's plan for seizure management between the physician and school health personnel of the Escambia County Health Department and the School District of Escambia County. Furthermore, if my child is covered by Medicaid and receives health services under an IEP, I consent for the school district to bill Medicaid for those services.

Parent/Guardian Signature: _____ **Date:** _____