Manatee County School Health Services
Individualized Seizure Management Plan (ISMP)

School Name: ________________ Phone Number: ______________ Fax#: _____________ School Year: ____________

Student Name: _____________________ DOB: __________________________ Grade: _________________
Mother/Guardian: __________________ Phone: ________________________ Cell: __________________
Father/Guardian: ___________________ Phone: ________________________ Cell: __________________
Significant Medical History: ____
Allergies: ____ Teacher: ____________________________

SEIZURE INFORMATION

Seizure Type (s)	Description	
□ Focal Aware Seizures	• Remains conscious, fully aware • rhythmic twitching or jerking of face and/or extremities • May experience tingling, visual changes, smells, sounds	• May have changes in thinking, feelings, perceptions (fear, anxiety). • Other ____________________________ • Last Known seizure ______________________
□ Focal Impaired Awareness Seizures	•Not aware, or confused • May have a blank dazed stare • May not be able to talk	• Clumsy or disorientated movements • Aimless walking or running • Other ____________________________________ • Last known seizure _________________________
□ Generalized Non- Motor (Absence) Seizures	•Pause in activity with blank stare • Brief lapse of awareness •May occur may times a day • Length: less than 20 seconds	• Possible chewing or blinking motion • Often confused with daydreaming and or attention problems • Other ___________________________________ • Last seizure ______________________________
□ Generalized Tonic-Clonic	• A sudden, horse cry • Loss of consciousness • Stiff body, arms and legs then rhythmic jerking	• Shallow breathing, drooling may occur • Possible loss of bowel or bladder control • Other ___________________________________ • Last known seizure ________________________

Seizure Triggers or warning signs: ____
Seizure usually lasts ______________ minutes and returns to baseline in ______________ minutes.
Students ability to manage and/understand their epilepsy or seizure disorder: (choose one)
□ Poor □ Developing □ Competent □ Expert □ Other ____________________

EMERGENCY MEDICATIONS

Diagnosis: ____ **ICD 10:** _____________________

Medication	Dosage	Route	Frequency	Side Effects

Does the student have a Vagus Nerve Stimulator (VNS) □ No □ Yes, Describe magnet use ______________________________

EMERGENCY RESPONSE: (Check all that apply)

A "seizure emergency" for this student is defined as: ____

Seizure Emergency Protocol:

□Contact School Nurse
□ Parent to notify doctor
□ Call 911 for all seizures
□ notify parent or emergency contact
□ Call 911 if the seizures do not stop after _____ minutes, and not responding to rescue medication if available.
□ Call 911 for any signs of difficulty in breathing
□ Call 911 if the student has a seizure and has diabetes or is injured
□ Call 911 if the student is slow to recover and has a second seizure
□ Call 911 if the student has repeated seizures without regaining consciousness

Individualized Seizure Management Plan (page 2)

STUDENT ACCOMMODATIONS & SAFETY PRECAUTIONS (check all that apply)

□ None
□ No swimming
□ No contact sports
□ No use of power tools/power equipment
□ No PE
□ Student needs to leave classroom before fire drills
□ Other: ____
□ Does the student need to leave the classroom after a seizure? □ YES □ No

Physician/Licensed Prescriber Signature:

Physician's Name: ________________________ Phone# ________________ Fax# ____________________
Physician's Address: ____ ________________
Physician's Signature ____ Date: ___________________

The following section is to be completed by the parent or legal guardian:

I hereby grant permission to the principal (or his/her designee) of my child's school to administer the above prescribed medication to my child while in school and away from school while participating in official school activities (F.S. 1006.062). It is my responsibility to notify the school if and when these orders change. I understand the law provides that there shall be no liability for civil damages as a result of the administration of such medication where the person administering such medication acts as an ordinary reasonably prudent person would under the same or similar circumstances. I understand the school will not be responsible for monitoring a student's self medication.

Name: ____ Relationship: _____________________________
Cell Phone# _____________________Home Phone # ______________________ Business Phone # ___________
Signature: Parent/Legal Guardian ____