

HUMBOLDT COUNTY SCHOOL DISTRICT
SEIZURE MEDICAL MANAGEMENT PLAN



Seizure Action Plan

Student Name: _____ DOB: _____

Date of Plan: _____ Seizure Type/Description: _____

Parent/Guardian Section

- ✓ I confirm my child's doctor has prescribed a seizure rescue medication.
- ✓ I give permission for trained school staff to give this medication if needed.
- ✓ I allow my child's doctor to share necessary information with the school nurse.
- ✓ I will notify the school of any medication or health changes.
- ✓ I understand that if I do not give permission, the only option in an emergency will be to call 911.

Parent Signature: _____ Date: _____

Provider's Section

- ✓ This student has a **seizure diagnosis** and needs emergency medication at school.
- ✓ Always **call 911, the parent, and the school nurse** when giving the medication.
- ✓ Trained school staff will administer the medication as needed.

Emergency Medication: (Check one)

- Midazolam** (nasal) – Dose: ____ mg
- Diazepam** (rectal, only an RN can give) – Dose: ____ ml
- Lorazepam** (IM)– Dose: ____
- Other: _____

When to Give the Medication:

- If a seizure lasts ____ **minutes or longer**
- If there are ____ **or more seizures** in ____ **minutes**
- Other: _____

Possible Side Effects:

- Breathing problems
- Nasal irritation
- Drowsiness or fatigue

- Memory loss
- Other: _____

Additional Instructions:

Doctor's Name: _____ **Date:** _____

Signature: _____ **Phone:** _____ **NPI#:** _____

School Nurse Section

✓ A personalized emergency plan will be made with the nurse and parent.

Nurse's Name: _____ **Date:** _____

School: _____ **Phone:** _____

Email: _____

**Per Nevada Revised Statutes: this order can only be signed by a MD/DO, nurse practitioner, or certified physician's assistant, is only valid for one calendar year, and must be updated upon change in medical condition.*