



PHYSICIAN'S PLAN OF CARE FOR ADMINISTRATION OF EMERGENCY SEIZURE MEDICATION

Student's Name: _____ Student Number: _____ Date of Birth: _____
Grade: _____ Allergies: _____ ICD 10 Code: _____
Physician Name: _____ Physician Phone: _____ Physician Fax: _____

It is necessary for the above student to have emergency seizure medications for the following type of seizures activity:

ADMINISTRATION PROTOCOL:

Vagal Nerve Stimulator (VNS) _____ YES _____ NO

Trained school personnel will swipe magnet:

- ☐ At onset of seizure activity
- ☐ Within _____ minutes
- ☐ If seizure continues, wait _____ minute(s) and repeat swipe
- ☐ Repeat _____ times _____ minute(s) in between swipes

Emergency Seizure Medication:

Trained school personnel will give the below emergency seizure medication:

- ☐ Nayzilam (Midazolam) _____ mgs (nasal)
- ☐ Valtoco (Diazepam) _____ mgs (nasal)
- ☐ Diastat (Diazepam) _____ mgs (rectal)

Administer Above Medication:

- ☐ At onset of any seizure
- ☐ At _____ minutes after onset of seizure
- ☐ Other _____

Call 911:

- ☐ At onset of any seizure.
- ☐ At _____ minutes after onset of seizure.
- ☐ After using VNS magnet _____ times

(If Emergency medication is given 911 will be called per CCPS guidelines)

During transport:

Since seizure emergency medications and VNS magnet cannot be given on a school bus or while in transit, 911 should be called:

- ☐ At onset of any seizure.
- ☐ At _____ minutes after onset of seizure

STANDARDIZED PROCEDURES:

- ☐ I have reviewed and approved the proposed plan of care for this student with the specific modifications below:

Precautions, possible side effects to observe: _____

Recommended interventions for side effects: _____

The above treatment(s)/intervention(s) are to be continued until _____
(Expiration Date)

I give permission for my child's doctor to be contacted for information regarding the administration of this medication.

Physician's Printed Name

Physician's Signature

Date

Parent/Guardian Printed Name

Parent/Guardian Signature

Date

Reviewed by _____
School Nurse

Date