EUSTACE ISD
HEALTH SERVICES DEPARTMENT

Seizure Management and Treatment Plan

Student's Name: _____ **DOB:** _____ **Student ID#**_____

Diagnosis/Medical History_____

Seizure Type	Length	Frequency	Description

Seizure triggers:
Seizure warning signs:
Student's response after a seizure:
Self-care ability & understanding of seizures:

Basic Seizure First Aid: Care & Comfort	**Emergency Response - Eustace ISD will call 911 for:**
Basic seizure first aid will be provided and parent will be contacted. Indicate any special care for this student:	♦Convulsive seizure lasting >5 minutes or 1st time seizure ♦Repeated seizures without regaining consciousness ♦Injured; has breathing difficulties ♦Pregnant; has diabetes; high fever; seizure in water ♦**After emergency seizure medication has been given***

If a seizure should occur while a student is being transported on the school bus, at a field trip or off-campus site, 911 will be called and basic seizure first aid will be provided.

Treatment, emergency & daily medications needed during school hours
Include instructions for duration of seizure (minutes) or number of seizures per period of time.
The school administrator may assign and the school RN train an unlicensed school employee to administer diazepam rectal gel or Nayzilam®. **IN midazolam will only be administered by the campus nurse.**

Medication	Dose/Route	Frequency and Instructions
Diazepam rectal gel		
IN midazolam		
Nayzilam®		
Vagus Nerve Stimulator	magnet	

Special Considerations and Precautions (school activities, sports, trips, etc.). *****Please explain in detail any other special issues or explain circumstances where it is not necessary to call 911.

I request and authorize the above medication(s) and treatments. I have determined requested off-label medication is necessary at school and further state that this medication has been clinically determined to be safe and effective based on this student's health needs.

_____ _____ _____ _____

(Physician Signature) (Print Name) (Date) (Phone)

I request and authorize Eustace ISD to administer the above medication and treatment. I acknowledge that I understand the Student Handbook Medication Procedures and understand trained, assigned staff may provide care. I authorize the school licensed nurse and prescribing healthcare provider to confidentially discuss or clarify this medication order, and to discuss the student's response to the medication as required by law (Nurse Practice and Medical Practice Acts of Texas).

_____ _____ _____ _____

(Parent/Guardian Signature) (Print Name) (Date) (Phone)

Policy FFAC(LEGAL/LOCAL); FFAF(LEGAL)
Health Services 8/2025 Adapted from Epilepsy Foundation *Seizure Action Plan*