Seminole County Public Schools Health Services

Seizure Medical Management Plan

School Year 2017 - 2018

TO BE COMPLETED BY PARENT

Student Name [redacted] Date of Birth [redacted]

School English Estates Grade ______

Allergies ______

CONTACT INFORMATION

Parent/Guardian [redacted] Phone [redacted]

Parent/Guardian ______ Phone ______

The following section is to be completed by the prescribing licensed healthcare provider. Please be aware that this medication may be administered by trained unlicensed school personnel.

FOR LICENSED HEALTH CARE PROVIDER USE ONLY

Describe the type and duration of seizures that require the administration of the medication listed below.

Type GTC or Focal seizure Duration > 3 minutes

Medication Midazolam Strength 10mg/ml Dosage 0.3ml per nostril Route nasal

Additional administration instructions May repeat 1 time if seizure doesn't stop after 5 mins.

List any significant side effects to this medication drowsiness, headache, nausea

Oxygen N/A

Other considerations Do not restrict patient during seizure, keep pt on her side

Licensed Health Care Provider Signature ______ Date 08/11/2017

Printed Name Joo Hee Seo, MD Phone 407-303-8122

Address 615 E. Princeton St. 540, Orlando FL 32803 Fax 407-303-8197

Electronically signed by [illegible] on 08/11/2017 [illegible]:07 AM

The following section is to be completed by parent/guardian:

- I hereby grant permission to Seminole County Public Schools and its designees to assist in the administration of the above-prescribed medication to my child while in school and during school sponsored activities (FS 1006.062).
- I give permission for my child's doctor to be contacted if needed, regarding administration of the above medication.
- It is my responsibility to provide a new medication authorization form if and when these orders change.
- Medication must be in the container in which it was purchased. Prescription medications must have a pharmacy label attached that matches this authorization.
- *I understand that if emergency medication is administered 911 will be called to evaluate my child. I further understand that if EMS determines my child does not need to be transported to the hospital, it is my responsibility to arrange for my child to be picked up from school immediately (within 30 minutes) for follow-up monitoring.*

Parent/Legal Guardian Signature ______ Date ______

Parent/Legal Guardian Printed Name ______

School Board Nurse Signature ______ Date ______

THIS AUTHORIZATION IS VALID FOR THE CURRENT SCHOOL YEAR ONLY, INCLUDING SUMMER SCHOOL

Rev. 2/2017

Todd M Nusty 11-16-17

Medical Director SCFD

09/21/2017 07:57
09-20-17;01:10PM;

(FAX)

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SEMINOLE COUNTY PUBLIC SCHOOLS
STUDENT MEDICATION AUTHORIZATION

Student Picture

Student Name: [redacted] Sex: M DOB: [redacted] School Year: 17-18

School: Winter Springs Elem Grade: PK Phone: [redacted] Fax: [redacted]

The following section is to be completed by the prescribing licensed healthcare provider prior to administering medication. Please be aware that this medication may be administered by trained unlicensed school personnel.

MEDICATION INFORMATION

FOR LICENSED HEALTHCARE PROVIDER USE ONLY:

Condition for which medication is being administered: Adrenal Insufficiency

Name of medication/strength: Solu-Cortef

Route to administer (please check one): ☐ Oral ☐ Inhaled ☒ Injected ☐ Topical ☐ Other (describe)

Dosage: 50mg IM Frequency: Once PRN unresponsiveness, seizures Time of Day:

If to be given as needed, for what symptoms? unresponsiveness, seizure

List any significant side effects to medication:

FOR SELF CARRY/SELF ADMINISTRATION OF EMERGENCY MEDICATION AND PANCREATIC ENZYMES:

- In accordance with FS 1002.20, I authorize this student to carry and self-administer the inhaler, epinephrine auto-injector or, pancreatic enzymes as described above and have instructed the student on its use. ☐ Yes ☒ No

FOR HIGH SCHOOL STUDENTS ONLY:

- Is this high school student authorized to carry and self-administer his/her medication? ☐ Yes ☐ No N/A

THIS AUTHORIZATION IS VALID FOR THE CURRENT SCHOOL YEAR ONLY, INCLUDING SUMMER SCHOOL.

Licensed Health Care Provider Signature: [illegible] Date: 9/20/17

Printed Name: Jennifer Villar Phone Number: 321-841-3303

Address: 601 W Gore St. 2nd Floor Orlando, FL 32806 Fax Number: 321-841-3305

[illegible]

Todd M Husty, Medical Director SCFD
11-16-17

SEMINOLE COUNTY PUBLIC SCHOOLS
STUDENT MEDICATION AUTHORIZATION

Student Name: [redacted] Sex: M Date 12-31-[illegible] [redacted]

School: Lyman High School Grade 10th Phone: [redacted] [redacted]

Condition for which medication is being administered: Panhypopituitarism

Name of Drug: Solu-Cortef 100mg injection

Route to administer: ☐ Oral ☐ Inhaled ☒ Injected ☐ Topical ☐ Other (Specify)

Dosage: 50mg Frequency: As needed Time of Day: N/a

If to be given as needed, for what symptoms: Incase of severe illness such as fever more than 102 F or severe trauma

List any significant side effects to monitor: Hypertension, Increased Stress Change

• N/a

• N/a

THIS AUTHORIZATION IS VALID FOR THE CURRENT SCHOOL YEAR ONLY, INCLUDING SUMMER SCHOOL.

Licensed Health Care Provider Signature: Date 7/26/17

Printed Name: Yumnes Yi MD

Phone Number: 407-650-7210

Address: 3200 W. Lake Mary Blvd ste 100 Fax Number: 407-650-7211
Lake Mary FL 32746

Parent/Legal Guardian Signature: [redacted] Date: [redacted]

Parent/Legal Guardian Printed Name: [redacted] Relationship: [redacted]

Primary Phone: [redacted] Other Phone:

Todd M Husty, Medical Director SCFD