EPILEPSY / SEIZURE – Plan of Care

518-4

Student Name: _____ Date of Birth: _____

Student Photo

Grade: _____ Teacher: _____

Student's Approximate Weight: _____

EMERGENCY CONTACTS (LIST IN PRIORITY)

NAME	RELATIONSHIP	DAYTIME PHONE	ALTERNATIVE PHONE
1.			
2.			
3.			

KNOWN SEIZURE TRIGGERS

SELECT ALL THOSE THAT APPLY

❒ Stress ❒ Menstrual Cycle ❒ Inactivity ❒ Changes in Diet

❒ Lack of Sleep ❒ Electronic Stimulation (TV, Videos, Florescent Lights) ❒ Illness ❒ Improper Medication Balance

❒ Change in Weather

❒ Other: _____

Any Other Medical Condition or Allergy: _____

Has an emergency rescue medication been prescribed? ❒ Yes ❒ No

If yes, attach the rescue medication plan, healthcare providers' orders and authorization from the student's parent(s)/guardian(s) for a trained person (e.g. LHIN) to administer the medication.

Note: Rescue medication training for the prescribed rescue medication and route of administration (e.g. buccal or intranasal) must be done in collaboration with a regulated healthcare professional.

EMERGENCY PROCEDURES

Students with epilepsy will typically experience seizures as a result of their medical condition.

Call 911 when:

- Convulsive (tonic-clonic) seizure lasts longer than five (5) minutes.
- Student has repeated seizures without regaining consciousness.
- Student is injured or has diabetes.
- Student has a first-time seizure.
- Student has breathing difficulties.
- Student has a seizure in water.

Notify parent(s)/guardian(s) or emergency contact.

DAILY/ROUTINE EPILEPSY MANAGEMENT

DESCRIPTION OF SEIZURE (NON-CONVULSIVE)	ACTION:
	(e.g. description of dietary therapy, risks to be mitigated, trigger avoidance)

DESCRIPTION OF SEIZURE (CONVULSIVE)	ACTION:

SEIZURE MANAGEMENT

Note: It is possible for a student to have more than one seizure type. Record information for each seizure type.

SEIZURE TYPE	ACTIONS TO TAKE DURING SEIZURE
(e.g. tonic-clonic, absence, simple partial, complex partial, atonic, myoclonic, infantile spasms) Type: _____ Description: _____ _____	

Frequency of seizure activity:

_____

_____

Typical seizure duration:

_____

BASIC FIRST AID: CARE AND COMFORT

First Aid Procedure(s):

_____

_____

Does student need to leave classroom after a seizure: ❒ Yes ❒ No

If yes, describe process for returning student to classroom:

_____

_____

BASIC SEIZURE FIRST AID:

- Stay calm and track time and duration of seizure
- Keep student safe
- Do not restrain or interfere with student's movements
- Do not put anything in student's mouth
- Stay with student until fully conscious

FOR TONIC-CLONIC SEIZURE:

- Protect student's head
- Keep airway open/watch breathing
- Turn student on side

HEALTHCARE PROVIDER INFORMATION

I hereby agree with the diagnosis of this student, the medication, and the plan above.

_____ _____ _____

Health Care Provider (Please print) Signature Date

AUTHORIZATION / PLAN REVIEW

This Plan remains in effect for the 20___ - 20___ school year. (It is the parent(s)/guardian(s) responsibility to notify the principal if there is a need to change the Plan of Care during the school year).

Parent(s)/Guardian(s)/Student (if age 18+)

_____ _____

Signature Date

_____ *(Parent Initial) I authorize the sharing of this plan with principals, teachers, support staff, volunteers, bus operators and drivers, and other adults as appropriate, which may include the posting in designated locations.*

_____ *(Parent Initial) I authorize the sharing of signs and symptoms of this medical condition with other students.*

Authorization for the collection of this information is in the Education Act. The purpose is to collect and share medical information and to administer proper medical care in the event of an emergency or life-threatening situation. The original form and all copies will be retained and securely destroyed in accordance with the board's Records Management Manual and Policy 316. Contact person concerning this collection is the school principal.