# Prevalent Medical Conditions: Student Epilepsy Plan of Care

| **Student Information** | | |
|---|---|---|
| Student Name: | Date of Birth: | STUDENT PICTURE HERE 2 " X 3" |
| Address: | | |
| Ontario Ed. #: | Age: | |
| Grade: | Teacher(s): | |

| **Emergency contacts (List in Priority)** | | | |
|---|---|---|---|
| **Name** | **Relationship** | **Daytime Phone** | **Alternate Phone** |
| **1.** | | | |
| **2.** | | | |
| 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 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. | | | |

| **Known Seizure Triggers** (check all those that apply) | | |
|---|---|---|
| ☐ Stress | ☐ Menstrual Cycle | ☐ Inactivity |
| ☐ Changes in Diet | ☐ Lack of Sleep | ☐ Electronic Stimulation (TV, Videos, Fluorescent Lights) |
| ☐ Illness | ☐ Improper Medication Balance | |
| ☐ Change in Weather | ☐ Other: | |
| ☐ Any other medical Condition or Allergy? | | |

| **Daily/Routine Epilepsy Management** | |
|---|---|
| **Description of Seizure**<br>(non-Convulsive) | **Action:** |
| | (e.g. description of dietary therapy, risks to be mitigated, trigger avoidance.) |
| **Description of Seizure**<br>(convulsive) | **Action:** |
| | |

| **Seizure Management** | |
|---|---|
| Note: It is possible for a student to have more than one seizure type.<br>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)<br><br>Type:<br>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

| **EMERGENCY PROCEDURES** |
|---|
| Students with epilepsy will typically experience seizures as a result of their medical condition. |

**CALL 9-1-1 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 the water.

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

| **Healthcare Provider Information (Optional)** | |
|---|---|
| Healthcare Provider's Name: | |
| Profession/Role: | |
| Signature: | Date: |
| Special Instructions/Notes/Prescription Labels: | |
| If medication is prescribed, please include dosage, frequency and method of administration, dates for which the authorization to administer applies and possible side effects.<br>**This information may remain on file if there are no changes to the student's medical condition. | |

| Authorization/Plan Review | | |
|---|---|---|
| Individuals with whom this Plan of Care is to be shared | | |
| 1. | 2. | 3. |
| 4. | 5. | 6. |
| Other individuals to be contacted regarding plan of care: | | |
| Before-School program | ☐ YES ☒ NO | |
| After-School program | ☐ YES ☒ NO | |
| School Bus Driver/Route # (if applicable) | | |
| Food services (if applicable) | | |
| This plan remains in effect for the 20YY – 20YY school year without change and will be reviewed on or before: [Enter Date]. (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/Guardian: _____ Date:_____
Signature

Student (if 18 years or older): _____ Date:_____
Signature

Principal: _____ Date: _____
Signature

**Information Collection Authorization**

*Notice of Collection: The personal information you have provided on this form and any other correspondence relating to your involvement in our programs is collected by the District School Board under the authority of the Education Act (R.S.O. 1990 c.E.2) ss. 58.5, 265 and 266 as amended and in accordance with Section 29(2) of the Municipal Freedom and Protection of Privacy Act, 1989.The information will be used to register and place the student in a school, or for a consistent purpose such as the allocation of staff and resources and to give information to employees to carry out their job duties. In addition, the information may be used to deal with matters of health and safety or discipline and is required to be disclosed in compelling circumstances or for law enforcement matters or in accordance with any other Act. The information will be used in accordance with the Education Act, the regulations, and guidelines issued by the Minister of Education governing the establishment, maintenance, use, retention, transfer and disposal of pupil records. If you have any questions, please contact the school principal and/or the Freedom of Information Officer, Brant Haldimand Norfolk Catholic District School Board, 322 Fairview Drive, Brantford, ON, N3T 5M8 (Telephone 519-756-6505, Ext. 234)*