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| **PREVALENT MEDICAL CONDITION — EPILEPSY****Plan of Care** |
| **STUDENT INFORMATION** |
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| Student Name       | Date Of Birth       |
| Ontario Ed. #       | Age       |
| Grade       | Teacher(s)       |

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| **EMERGENCY CONTACTS (LIST IN PRIORITY)**  |
| NAME | RELATIONSHIP  | DAYTIME PHONE | ALTERNATE PHONE  |
| 1.      |       |       |       |
| 2.      |       |       |       |
| 3.      |       |       |       |

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| Has an emergency rescue medication been prescribed? [ ]  Yes [ ]  No

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| 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. |
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| 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. |

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| **KNOWN SEIZURE TRIGGERS** |
| CHECK (x) 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?       |

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| **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:       |

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| **BASIC FIRST AID: CARE AND COMFORT** |
| First aid procedures:       |
| Does student need to leave classroom after a seizure? [ ]  Yes [ ]  NoIf 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.
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| **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 water.
* Notify parent(s)/guardian(s) or emergency contact.
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| **HEALTHCARE PROVIDER INFORMATION**  |
| **Healthcare provider may include:** Physician, Nurse Practitioner, Registered Nurse, Pharmacist, Respiratory Therapist, Certified Respiratory Educator, or Certified Asthma Educator. |
| 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.🟏This information may remain on file if there are no changes to the student’s medical condition. |

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| **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):  |       |  |
| Other: |       |  |  |  |
| **This plan remains in effect for the 20****— 20****school year without change and will be reviewed on or before:** Click or tap to enter a 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(s)/Guardian(s): |  | Date: |  |
|  Signature |  |  |
| Student: |  | Date: |  |
|  Signature |  |  |
| Principal: |  | Date: |  |
|  Signature |  |  |