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| **PREVALENT MEDICAL CONDITION — EPILEPSY**  **Plan of Care** | | |
| **STUDENT INFORMATION** | | |
|  | |  |
| 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   |  | | --- | | 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 (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  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 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 | | | | | |  |  | |