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| **PREVALENT MEDICAL CONDITION — EPILEPSY**  **Plan of Care** | | |
| **STUDENT INFORMATION** | | |
|  | | Student Photo (optional) |
| 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. |  | |  | |  |
|  |  | |  | |  |
| 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. | | | | | |
| **KNOWN SEIZURE TRIGGERS** | | | | | |
| CHECK (✓) 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.) |
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| **DESCRIPTION OF SEIZURE (CONVULSIVE)** | **ACTION:** |
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| **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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
|  |  |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
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| Typical seizure duration: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |

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| **BASIC FIRST AID: CARE AND COMFORT** |
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| First aid procedure(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |
| Does student need to leave classroom after a seizure? ❒ Yes ❒ No |
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| If yes, describe process for returning student to classroom: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
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| **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 |
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| **FOR TONIC-CLONIC SEIZURE:** |
| Protect student’s head |
| Keep airway open/watch breathing |
| Turn student on side |
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| **EMERGENCY PROCEDURES** |
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| Students with epilepsy will typically experience seizures as a result of their medical condition. |
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| Call 9-1-1 when: |
| • Convulsive (tonic-clonic) seizure lasts longer than five (5) minutes. |
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| • Student has repeated seizures without regaining consciousness. |
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| • Student is injured or has diabetes. |
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| • Student has a first-time seizure. |
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| •Student has breathing difficulties. |
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| • Student has a seizure in water |
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| 🟏Notify parent(s)/guardian(s) or emergency contact. |
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| **HEALTHCARE PROVIDER INFORMATION (OPTIONAL)** | |
| **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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
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| Special Instructions/Notes/Prescription Labels: | |
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| 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:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. (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). | | | | | | |
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| Parent(s)/Guardian(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | |
|  | | | Signature | | |  |
|  | | |  | | |  |
| Student: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | |
|  | | | Signature | | |  |
|  | | |  | | |  |
| Principal: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | |
|  | | | Signature | | |  |