Plan of Care:

EPILEPSY

School Year: 20__- 20__

Student Name	**DOB**	**Gender**	**Student Photo**
Address		**Student #**	
Exceptionality:	**Medic Alert I.D.** **Yes ☐ No ☐**	**OEN#**	
Grade	**Age**	**Teacher(s)**	

EMERGENCY CONTACT (LIST IN PRIORITY)			
NAME:	RELATIONSHIP	MAIN CONTACT #	ALTERNATE #
1.			
2.			
3.			
4.			

(HAVE ABILITY TO ADD MORE CONTACTS)

EPILEPSY SUPPORTS

Name of trained individuals who will provide support with epilepsy-related tasks:

Designated Staff:_____

LHIN Care Workers(if applicable):_____

Method of home-school communication:_____

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 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, Florescent Lights)
☼ Illness	☼ Improper Medication Balance	
☼ Change In Weather	☼ Other _____	

☼ Any Other Medical Condition or Allergy?

_____

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

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

FOR TONIC-CLONIC SEIZURE:

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

ILLNESS

When students with epilepsy has a seizure at school, the parent/guardian/caregiver should be notified immediately so that they can take appropriate action.

Comments:_____
_____
_____

EXCURSION PROTOCOL

During all trips off school property, an excursion kit will be provided which will consist of:

- ☐ Pocket emergency card
- ☐ Cell phone (if parent/guardian/caregiver chooses)

EMERGENCY PROCEDURES

DO NOT LEAVE STUDENT UNATTENDED

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

Call 9-1-1 when:

- ❿ Convulsive (tonic-clonic) seizure lasts longer than five (5) minutes.
- ❿ Student has repeated seizures without regaining consciousness.
- ❿ Student is injured or has diabetes.
- ❿ Student has a first-time seizure.
- ❿ Student has breathing difficulties.
- ❿ Student has a seizure in water
- 🗐 Notify parent(s)/guardian(s) or emergency contact.

Consent for student to carry and self-administer Epilepsy medication

We agree that _____,
(student name)

☐ can **carry** prescribed medications and delivery devices to manage Diabetes while at school and during school-related activities.
☐ can **self-administer** prescribed medications and delivery devices to manage Diabetes while at school and during school-related activities.
☐ **requires assistance** with administering prescribed medications and delivery devices to manage Diabetes while at school and during school-related activities.

☐ **It is the parent/guardian responsibility to notify the principal if there is a need to change the plan of care during the school year and to inform the school of any change of medication or delivery device**. This medication **cannot** be beyond the expiration date. **This plan remains in effect for the 20__--20__ school year without change and will be reviewed on or before: _____.**

Parent/Guardian Name: _____ Signature: _____ Date: _____

Parent/Guardian Name: _____ Signature: _____ Date: _____

Student Name: _____ Signature: _____ Date: _____

Principal Name: _____ Signature: _____ Date: _____

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/Comments:

- 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

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.

Parent(s)/Guardian(s): _____Date: _____
(signature)

Student: _____ Date: _____
(signature)

Principal: _____ Date:_____
(signature)