



INDIVIDUAL EPILEPSY PLAN OF CARE

STUDENT INFORMATION

Student Name _____ Date Of Birth _____

Ontario Ed. # _____ Age _____

Grade _____ Teacher(s) _____

Student Colour Photo

EMERGENCY CONTACTS (LIST IN PRIORITY)

NAME	RELATIONSHIP	DAYTIME PHONE	ALTERNATE PHONE
1.			
2.			
3.			

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

- | | | |
|--|--|--|
| <input type="checkbox"/> Stress | <input type="checkbox"/> Menstrual Cycle | <input type="checkbox"/> Inactivity |
| <input type="checkbox"/> Changes In Diet | <input type="checkbox"/> Lack Of Sleep | <input type="checkbox"/> Electronic Stimulation
(TV, Videos, Florescent Lights) |
| <input type="checkbox"/> Illness | <input type="checkbox"/> Improper Medication Balance | |
| <input type="checkbox"/> Change In
Weather | <input type="checkbox"/> Other _____ | |
| <input type="checkbox"/> Any Other Medical Condition or Allergy? _____ | | |

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 water
- ★ Notify parent(s)/guardian(s) or emergency contact.

Refer to Appendix L – Policy Manual – Student Miscellaneous - S.M.19 Epilepsy

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: _____

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.

AUTHORIZATION/PLAN REVIEW

INDIVIDUALS WITH WHOM THIS PLAN OF CARE IS TO BE SHARED

	Yes (Please Initial for each)	No (Please Initial for each)
We, the Parents/Guardians/ Adult Student request the posting of this Individual Plan of Care in the:	School Staff Room	
	Elementary Homeroom Classroom	
	School Main Office	
We the Parents/Guardians/Adult Student request the sharing of this plan with individuals which include, but are not limited to classroom teachers, occasional teachers, itinerant teachers, educational assistants, coaches, other school staff, and school bus drivers.		
We the Parents/Guardians/ Adult Student request the sharing of information on signs and symptoms of Epilepsy with students in the classroom.		
We, the Parents/Guardians/ Adult Student request the sharing of this Individual Plan of Care with the Before and After-School Program.		
We the Parents/Guardians/Adult Student consent to the carrying of the medication on his/her person.		
We the Parents/Guardians/Adult Student consent to the self-administration of medication.		

TRANSPORTATION

School Bus Driver/Route # (If Applicable) New Plan of Care Updated Plan of Care

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:
Adult Student:	Date:
Principal:	Date: