

**PREVALENT MEDICAL CONDITION — EPILEPSY / SEIZURE DISORDER**  
**Plan of Care**

**STUDENT INFORMATION**

Student Name \_\_\_\_\_ Date Of Birth \_\_\_\_\_

Ontario Ed. # \_\_\_\_\_ Age \_\_\_\_\_

Grade \_\_\_\_\_ Teacher(s) \_\_\_\_\_

Student Photo (optional)

**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<br>(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? _____ |  |  |

## 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
<p>(e.g. tonic-clonic, absence, simple partial, complex partial, atonic, myoclonic, infantile spasms)</p> <p>Type: _____</p> <p>Description: _____</p>	
<p>Frequency of seizure activity: _____</p> <p>_____</p>	
<p>Typical seizure duration: _____</p>	

## 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.

## 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

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