APPENDIX D: PLAN OF CARE — EPILEPSY

STUDENT INFORMATION

School	Age	Homeroom Teacher	Student Name

Student Name _____ Date Of Birth _____

Ontario Ed. # _____ Age _____

Grade _____ Teacher(s) _____

Other medical condition/allergy? MedicAlert® ID ☐ Yes ☐ No

_____

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) 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 _____

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STUDENT INFORMATION

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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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STUDENT INFORMATION

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_____	_____	_____	_____

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

Make necessary accommodations to seating arrangements, rest periods and testing for student safety and wellbeing.

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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STUDENT INFORMATION

School	Age	Homeroom Teacher	Student Name
_____	_____	_____	_____

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

Please select one of the following:

☐ DSBN Teaching and Support Staff, Niagara Student Transportation Services and food service providers.

☐ Only those listed below:

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

Personal information and personal health information on this form is collected, used and disclosed in accordance with the Education Act, R.S.O. 1990, c.E.2, as amended, the Municipal Freedom of Information and Protection of Privacy Act. R.S.O 1990, c.M. 56, as amended and the Personal Health Information Protection Act, 2004, c.3 Sched. A., as amended and will be used for the purpose of providing student health information for the Plan of Care and any similar or related purpose(s). Questions about this collection, use and disclosure should be directed to the Freedom of Information Coordinator, District School Board of Niagara, 191 Carlton Street, St. Catharines, ON L2R 7P4 905-641-1550