EPILEPSY (Seizure Disorders) –HEALTH CARE PLAN

STUDENT INFORMATION

Student Name _____ Date Of Birth _____

Age _____

Student Photo (optional)

Grade Teacher(s)

_____

EMERGENCY PROCEDURES

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.

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_____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.

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? _____

EMERGENCY CONTACTS (LIST IN PRIORITY)

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

DAILY ROUTINE SEIZURE MANAGEMENT

Note: it is possible for a student to have more than one seizure type. Record information for each seizure type. (e.g., tonic-clonic, absence, simple partial, complex partial, atonic, myoclonic, infantile, spasms)

SEIZURE TYPE	PREVENTATIVE ACTIONS	ACTIONS TO TAKE DURING SEIZURE
Type: Description: Frequency of Seizure Activity: Typical Seizure Duration: Known Triggers:		
Type: Description: Frequency of Seizure Activity: Typical Seizure Duration: Known Triggers:		

Storage and location of spare medication and other supplies if applicable:
_____
_____

Disposal of unused medication and medical supplies if applicable (supply and disposal of unused medication and/or medical supplies are facilitated by the family):
_____
_____

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

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: _____unless otherwise notified by parents of need to revisit the Plan. (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.)

I/We hereby request that the York Region District School Board, its employees or agents, as outlined, administer the above procedure to my/our child. The York Region District School Board employees are expected to support the student's daily or routine management, and respond to medical incidents

and medical emergencies that occur during school, as outlined in board policies and procedures. Parent(s)/guardians and students acknowledge that the employees of the York Region District School Board, who will administer the related procedures, are not medically trained. At all times it remains the responsibility of the parent(s)/guardians to ensure that clear instructions and current physician's orders are provided to the principal.

Parent(s)/Guardian(s): _____ Date: _____
Signature

Student: _____ Date: _____
Signature

Principal: _____ Date: _____
Signature

Authorization for the collection of this information is in accordance with the *Education Act*, the *Municipal Freedom of Information and Protection of Privacy Act*, and the *Personal Health Information Protection Act*, as amended and applicable. The purpose is to collect and share medical information and to administer proper medical care in the event of an emergency or life-threatening situation. Users of this information include but are not limited to principals, teachers, support staff, volunteers, and bus drivers. This form will be kept for a minimum period of one calendar year. Contact person concerning this collection is the school principal.

Distribution: Original: Secure location accessible by school staff

Original: Scanned and uploaded to SSNET

Original: Scanned and copy sent to Student

Transportation Services

Copy: Parent/Guardian

Copy: File in the OSR

RETAIN: Current school year + 1 year

Relevant Forms:

P662.02 Staff Administration of Medication

P662.03 Self-Administration of Medication

Medical Incident Record Form