Board Logo

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| EPILEPSY **Plan of Care** (Sample) | | |
| STUDENT INFORMATION | | |
|  | | Student Photo (optional) |
| Student Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date Of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Ontario Ed. # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Age \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Grade \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Teacher(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Other medical condition/allergy?  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | MedicAlert® ID  Yes  No |

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| EMERGENCY CONTACTS (LIST IN PRIORITY) | | | | | |
| NAME | RELATIONSHIP | | DAYTIME PHONE | | ALTERNATE PHONE |
| 1. |  | |  | |  |
| 2. |  | |  | |  |
| 3. |  | |  | |  |
|  | | | | | |
| Has an emergency rescue medication been prescribed?  Yes  No | | | | | |
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| 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. | | | | | |
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| 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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
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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.) |
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| DESCRIPTION OF SEIZURE (CONVULSIVE) | ACTION: |
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| 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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| BASIC FIRST AID: CARE AND COMFORT |
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| First aid procedure(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
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| Does student need to leave classroom after a seizure?  Yes  No |
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| If yes, describe process for returning student to classroom: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
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| **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 |
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| **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. |
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| EMERGENCY PROCEDURES |
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| Students with epilepsy will typically experience seizures as a result of their medical condition. | |
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| 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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| 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
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| Profession/Role: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
|  | |
| Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
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| Special Instructions/Notes/Prescription Labels: | |
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| 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. | |

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| 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 | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
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| After-School Program | Yes  No | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
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| School Bus Driver/Route # (If Applicable) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
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| Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
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| **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). | | | | |
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| Parent(s)/Guardian(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
|  | | Signature | |  |
|  | | | | |
| Student: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
|  | | Signature | |  |
|  | | | | |
| Principal: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
|  | | Signature | |  |