Board Logo

|  |
| --- |
| EPILEPSY**Plan of Care** (Sample) |
| STUDENT INFORMATION |
|  |

|  |
| --- |
| Insert Photo |

 |
| 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 or intranasal) must be done in collaboration with a regulated healthcare professional or Epilepsy Educator (PPM 161). |
| 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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |

|  |
| --- |
| 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, focal aware seizure, focal impaired awareness seizure, atonic, myoclonic, infantile spasms) |  |
| Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
|  |  |
| Description: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| Frequency of seizure activity: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |
| Typical seizure duration: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

|  |
| --- |
| 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. |

|  |
| --- |
| 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 |  |