Board Logo

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| **PREVALENT MEDICAL CONDITION — EPILEPSY****Plan of Care (Sample)** |
| **STUDENT INFORMATION** |
|  | Student Photo (optional) |
| Student Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date Of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Ontario Ed. # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Age \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Grade \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Teacher(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **EMERGENCY CONTACTS (LIST IN PRIORITY)**  |
| NAME | RELATIONSHIP  | DAYTIME PHONE | ALTERNATE PHONE  |
| 1. |  |  |  |
| 2. |  |  |  |
| 3. |  |  |  |
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| 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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| ❒ Any Other Medical Condition or Allergy? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
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| 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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| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
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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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| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
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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 |
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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. |
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|  • Student has repeated seizures without regaining consciousness. |
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|  • Student is injured or has diabetes. |
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|  • Student has a first-time seizure. |
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|  •Student has breathing difficulties. |
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|  • Student has a seizure in water |
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|  🟏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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
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| 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 | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |  |
| 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 |  |