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STUDENT EPILEPSY MANAGEMENT PLAN

STUDENT INFORMATION		
Student Name ________________	Date Of Birth ________________	Student Photo (optional)
Ontario Ed. # ________________	Age ________________	
Grade ________________	Teacher(s) ________________	

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.

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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STUDENT EPILEPSY MANAGEMENT PLAN

<table>
<tr><th colspan="2">DAILY/ROUTINE EPILEPSY MANAGEMENT</th></tr>
<tr><th>DESCRIPTION OF SEIZURE (NON-CONVULSIVE)</th><th>ACTION:</th></tr>
<tr><td></td><td>(e.g., description of dietary therapy, risks to be mitigated, trigger avoidance.)</td></tr>
<tr><th>DESCRIPTION OF SEIZURE (CONVULSIVE)</th><th>ACTION:</th></tr>
<tr><td></td><td></td></tr>
<tr><th colspan="2">SEIZURE MANAGEMENT</th></tr>
<tr><td colspan="2">Note: It is possible for a student to have more than one seizure type.
Record information for each seizure type.</td></tr>
<tr><th>SEIZURE TYPE</th><th>ACTIONS TO TAKE DURING SEIZURE</th></tr>
<tr><td>(e.g., tonic-clonic, absence, simple partial, complex partial, atonic, myoclonic, infantile spasms)

Type: ______________________________

Description: __________________________</td><td></td></tr>
<tr><td colspan="2">Frequency of seizure activity: ____

____

Typical seizure duration: ____</td></tr>
</table>

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STUDENT EPILEPSY MANAGEMENT PLAN

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

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 EPILEPSY MANAGEMENT PLAN

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