Student Epilepsy Management Plan

Appendix H

STUDENT INFORMATION	
Student Name ________________	Date Of Birth ________________
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? ____

____

STUDENT EPILEPSY MANAGEMENT PLAN

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, simple partial, complex partial, atonic, myoclonic, infantile spasms) Type: ______________________________ Description: __________________________	
Frequency of seizure activity: Typical seizure duration: ____	

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.

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:______________________________

STUDENT EPILEPSY MANAGEMENT PLAN

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