York Catholic District School Board

EPILEPSY HEALTH MANAGEMENT PLAN

STUDENT'S NAME: _____ **TEACHER'S NAME:** _____

DATE OF BIRTH: _____ **GRADE:** _____

PARENT'S NAME: _____ **PHONE #:** _____

PARENT'S NAME _____ **PHONE #:** _____

ALTERNATE EMERGENCY CONTACT INFO: _____

Home Address _____ Phone # _____ Physician's Name Phone #	**PLACE STUDENT'S PHOTO HERE (MUST BE KEPT CURRENT)**

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? _____

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. absence (petit mal), atonic, clonic, myoclonic, tonic, tonic-clonic (grand mal), simple partial, complex partial, infantile spasms) Type: _____ Description: _____	

Frequency of seizure activity: _____

_____

Typical seizure duration: _____

Action Plan for supporting school access (e.g.: access on the stairs, transition between classes, toileting routines)

_____

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 (unless directed on the action plan e.g. administration of sublingual medication)
- Stay with student until fully conscious

FOR TONIC-CLONIC SEIZURE:

Protect student's head
Watch breathing (turn student on side, assists with keeping the airway open)
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.

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).

Physician: _____ Date: _____
Signature

Parent(s)/Guardian(s): _____ Date: _____
Signature

Student: _____ Date:_____
Signature

Principal: _____ Date: _____
Signature