



**PREVALENT MEDICAL CONDITION — EPILEPSY/SEIZURE DISORDER**  
**Plan of Care**

**STUDENT INFORMATION**

Student Name: \_\_\_\_\_ Date Of Birth: \_\_\_\_\_

OEN: # \_\_\_\_\_ Age: \_\_\_\_\_ Grade: \_\_\_\_\_ Weight: \_\_\_\_\_

Program: \_\_\_IET \_\_\_Resource Teacher(s): \_\_\_\_\_

Student Photo

**EMERGENCY CONTACTS (LIST IN PRIORITY)**

First contact must be a parent.

NAME	RELATIONSHIP	DAYTIME PHONE	ALTERNATE PHONE
1.			
2.			
3.			

Has an emergency rescue medication been prescribed?  Yes  No

**If yes, the following section must be completed by a physician.**

Name of Medication

Method of Administration (*Dosage, time of administration*)

Additional Instructions

Name of Physician (*please print*)

Phone #

Signature of Physician

Date

### HISTORY OF KNOWN SEIZURE TRIGGERS

CHECK (✓) ALL THOSE THAT APPLY

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Stress            | <input type="checkbox"/> Fever              | <input type="checkbox"/> Excessive Activity  |
| <input type="checkbox"/> Changes In Diet   | <input type="checkbox"/> Lack Of Sleep      | <input type="checkbox"/> Electronic Stimulation<br>(TV, Videos, Florescent Lights) |
| <input type="checkbox"/> Heat/Over Heating | <input type="checkbox"/> Waking from Sleep  | <input type="checkbox"/> Illness   |
| <input type="checkbox"/> Change in Weather | <input type="checkbox"/> Medication changes |  |
| <input type="checkbox"/> Other _____       |   |  |

### DAILY/ROUTINE EPILEPSY/SEIZURE MANAGEMENT

Seizure type: tonic-clonic, absence, simple partial, complex partial, atonic, myoclonic, infantile spasms). It is possible for a student to have more than one seizure type. Please record information for each seizure type.

#### LIST SEIZURE TYPE & DESCRIPTION:

#### ACTION:

Please record any seizure management medication given at home.

(e.g. description of dietary therapy, risks to be mitigated, trigger avoidance.)

Frequency of seizure activity: \_\_\_\_\_  
\_\_\_\_\_

Typical seizure duration: \_\_\_\_\_

### EMERGENCY SEIZURE MANAGEMENT

#### SEIZURE TYPE & DESCRIPTION:

#### ACTIONS TO TAKE DURING SEIZURE

## BASIC FIRST AID: CARE AND COMFORT

### 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

## BSA EMERGENCY PROCEDURES

**STEP 1:** Call for the BSA Nurse STAT

**STEP 2:** If symptoms continue call **Code Blue** ext. 5555 as directed in Med Risk Binder

**STEP 3:** Call 9-1-1

**STEP 4:** Notify Parent(s)/Guardian(s)/ Emergency Contact (see page 1)

## AUTHORIZATION/PLAN REVIEW

I/we authorize the principal or principal designate to share the Plan of Care with school staff who are in direct contact with my child. For example the classroom teacher, educational assistants, therapy team, rotary teachers, occasional staff, appropriate Holland Bloorview staff such as Spiral Garden and pool, transportation providers and volunteers.

Other individuals to be contacted regarding Plan of Care: \_\_\_\_\_

**This plan remains in effect for the completion of the school year and will be reviewed annually. It is the parent's responsibility to notify the principal if there is a need to change the Plan of Care during the school year.**

I/we understand our child's personal health information will be disclosed between organizations to maximize the quality of education being provided to our child and this information will be held in confidence and maintained securely in accordance with Ontario's privacy law called the Personal Health Information Protection Act (PHIPA).

Parent(s)/Guardian(s): \_\_\_\_\_ Date: \_\_\_\_\_  
Signature

Principal: \_\_\_\_\_ Date: \_\_\_\_\_