Dream • Learn • Grow
Bloorview
SCHOOL AUTHORITY

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

KNOWN SEIZURE TRIGGERS

CHECK (✓) ALL THOSE THAT APPLY

❒ Stress
❒ Menstrual Cycle
❒ Inactivity
❒ Changes In Diet
❒ Lack Of Sleep
❒ Electronic Stimulation (TV, Videos, Florescent Lights)
❒ Heat/Over Heating
❒ Excessive Activity
❒ Illness
❒ Change in Weather
❒ Improper Medication Balance
❒ Other _____
❒ Any Other Medical Condition or Allergy? _____

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 an HCN STAT ext. 5555 to assess

STEP 2: If symptoms continue call Code Blue ext. 5555

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: _____