Dufferin-Peel Catholic District School Board

Plan of Care – Prevalent Medical Condition

Epilepsy / Other Seizure Disorders

GF 514.10E

STUDENT SPECIFIC

Student Name: _____ Date of Birth: _____ Age: _____

OEN Number: _____ Teacher: _____ Grade: _____

Medical Alert ID: Yes ☐ No ☐ (for high schools, indicate Semester 1 Homeroom Teacher)

Any other medical condition or allergy? _____

Insert Student Photo

Emergency Contact Information:

Name:	Relationship:	Contact Numbers:

List all known seizure triggers:

Stress		Illness		Changes in Weather	
Menstrual Cycle		Improper Medication Balance		Inactivity	
Electronic Stimulation (TV, videos, florescent lights)		Changes in Diet		Lack of Sleep	

Other: _____

Daily / Routine Management: Epilepsy and other Seizure Disorders (to be completed by a medical practitioner)

Description of Seizure (Non-Convulsive):	**Action:**
	(e.g. description of dietary therapy, risks to be mitigated, trigger avoidance)
Description of Seizure (Convulsive):	**Action:**
Seizure Type *(it is possible for a student to have more than one seizure type)*	**Action to take during seizure:**
☐ Tonic-clonic (formally known as Grand Mal) ☐ Absence (formally known as Petit Mal) ☐ Simple Partial ☐ Complex Partial ☐ Atonic ☐ Myoclonic ☐ Infantile spasms ☐ Other: _____	

Frequency of seizure activity: _____ Typical seizure duration: _____

Name of Emergency Rescue Medication: _____

***** 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***

Special accommodations to be considered (if applicable): _____

Possible side effects: _____

Additional instructions (e.g. storage of medication): _____

Disposal of Medication: _____

Medical Practitioner's Name: _____

Profession / Role: _____

Signature: _____ Date: _____
(Medical Practitioner)

☐ Emergency Rescue Medication will be stored in the office.

This is the primary and only kit. ☐ This is the secondary. ☐

☐ Student **will carry** their Emergency Rescue Medication **at all times**.

☐ If applicable, Emergency Rescue Medication will be stored in the student's locker. Locker # _____

Basic First Aid: Care and Comfort

First Aid Procedure(s): _____

_____

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 (formally known as Grand Mal Seizure):

- ✓ Protect student's head
- ✓ Keep airway open/watch breathing
- ✓ Turn student on side

Administrative / Plan Review

Individuals with whom this Plan of Care is to be shared:

☐ Principal or Principal Designate ☐ Teacher-in-Charge ☐ Administrative Assistant (s)

☐ Classroom Teacher(s) ☐ Planning Time Teacher(s) ☐ Resource Teacher(s) / Support Services

☐ Student Monitors/ Volunteers ☐ Occasional Teachers ☐ **ALL OF THE ABOVE**

Other individuals to be contacted regarding Plan of Care: (if applicable)

☐ PLASP / Daycare ☐ School Transportation ☐ Other: _____

As the parent of _____(student name), I have been an active participant in supporting the management of their child's medical condition(s) while he/she is in school.

☐ **Teachers and Principals and other school staff are not health professionals and have no more information about the medical condition of my child than that which has been provided to them. They are not experts in recognizing the symptoms of my child's medical condition or in treating it.**

☐ I have educated my child about his/her medical condition.

☐ I have encouraged my child to self-manage and self-advocate.

☐ I give consent to share information on signs and symptoms with other students (e.g. classmates).

☐ I have informed the school of my child's medical condition(s) and will communicate any changes or updates.

This plan remains in effect for the _____ school year without change and will be reviewed annually.

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 – if applicable)

Principal: _____ ***Date:*** _____
(signature)

General Seizure Response

Remain calm and reassure both the person and the onlookers.

- Take note of the time that the seizure began and length of seizure. (See Appendix A: Seizure Log)
- Move dangerous objects out of the way. Remove glasses and loosen tight collars or clothing. Place something soft under the head. Relocate the person only if in a dangerous position.
- Do not restrain or interfere with the person's movements. Let the seizure run its course.
- Do not place or force anything in the person's mouth.
- Post seizure, turn the person gently on the side to keep air passages clear.
- As consciousness returns, talk to the person in a soothing, reassuring way. Let him or her rest for a few minutes, help him or her get reoriented.
- Notify the parent(s)/guardian(s) that a seizure has occurred.

Emergency Response

CALL 911 IMMEDIATELY IF...

A PERSON NOT DIAGNOSED WITH EPILEPSY/SEIZURE DISORDER HAS A SEIZURE

OR

IF A CONVULSIVE SEIZURE...

- Convulsive (tonic-clonic) seizure lasts longer than 5 minutes.
- Continues beyond the threshold time articulated in the Plan of Care
- 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.

Complete OSBIE, if applicable.