

ST. CLAIR CATHOLIC DISTRICT SCHOOL BOARD

Student Epilepsy Management Plan

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.			

<p>Has an emergency rescue medication been prescribed? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>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.</p> <p>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.</p>															
KNOWN SEIZURE TRIGGERS															
CHECK (✓) ALL THOSE THAT APPLY															
<table style="width: 100%; border: none;"> <tr> <td style="width: 33%;"><input type="checkbox"/> Stress</td> <td style="width: 33%;"><input type="checkbox"/> Menstrual Cycle</td> <td style="width: 33%;"><input type="checkbox"/> Inactivity</td> </tr> <tr> <td><input type="checkbox"/> Changes In Diet</td> <td><input type="checkbox"/> Lack Of Sleep</td> <td><input type="checkbox"/> Electronic Stimulation (TV, Videos, Florescent Lights)</td> </tr> <tr> <td><input type="checkbox"/> Illness</td> <td colspan="2"><input type="checkbox"/> Improper Medication Balance</td> </tr> <tr> <td><input type="checkbox"/> Change In Weather</td> <td colspan="2"><input type="checkbox"/> Other _____</td> </tr> <tr> <td colspan="3"><input type="checkbox"/> Any Other Medical Condition or Allergy? _____</td> </tr> </table>	<input type="checkbox"/> Stress	<input type="checkbox"/> Menstrual Cycle	<input type="checkbox"/> Inactivity	<input type="checkbox"/> Changes In Diet	<input type="checkbox"/> Lack Of Sleep	<input type="checkbox"/> Electronic Stimulation (TV, Videos, Florescent Lights)	<input type="checkbox"/> Illness	<input type="checkbox"/> Improper Medication Balance		<input type="checkbox"/> Change In Weather	<input type="checkbox"/> Other _____		<input type="checkbox"/> Any Other Medical Condition or Allergy? _____		
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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: _____	

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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.

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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: _____

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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