Innovation Collaboration Wellness

Form 320

PREVALENT MEDICAL CONDITION — EPILEPSY
Plan of Care

STUDENT INFORMATION

Student Name _____ Date Of Birth _____

Ontario Ed. # _____ Age _____

Grade _____ Teacher(s) _____

Student Photo (optional)

EMERGENCY CONTACTS (LIST IN PRIORITY)

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

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

Frequency of seizure activity: _____

_____

Typical seizure duration: _____

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 (with the exception of emergency rescue medication as prescribed)
- 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.

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: _____

If medication is prescribed and will be administered at school, it is necessary to complete the following documents:

1) Form 314-A1, "Administration of Medication/Medical Procedures to Students"

2) Form 314-A2, :"Authorization and Request Form for the Administration of Prescribed Medication"

Are Forms 314-A1 and Forms 314-A2 required for this student? ❒ Yes ❒ No

TRANSPORTATION

Plan for Student Transportation

Individual Student Boarding	Individual Student Securement	Individual Student De-Boarding

Roles

School Staff	Parent/Guardian	Student	Transportation Provider	Operator/Driver
-Create and monitor this plan with parents/guardians, student, TriBoard, and school staff. -Advise TriBoard and parents/guardians of relevant issues while at school during the day.	-Communicate with the school any medical or other conditions affecting the safe transportation of the student for completion of this plan.	-Follow the bus rules and strategies listed on this plan. -Advise the driver of any medical emergency, or health issues that they are experiencing while being transported.	-Ensure that all drivers and monitors staffed to transport the student are aware of the strategies listed in this plan. -Ensure that all temporary staff that transport the student are aware of the	-Ensure that the student is transported safety according to needs listed on this plan. -Follow TriBoard and School Board policies and procedures for transporting students with disabilities.

-Help identify tools, or strategies that may help the driver and/or monitor while transporting the student.	-Communicate any changes to any medical or other conditions that might affect transportation. -Communicate with the school and driver any tool or strategies that will help the driver deliver and monitor the needs of the student while transporting them.	-Communicate with the driver if a listed strategy on this plan needs to be addressed or revisited for their comfort (if possible).	strategies listed in this plan. -Ensure that all temporary staff that transport the student are fully briefed on this plan. -Ensure that proper training of staff is in place regarding boarding, securing, and de-boarding practices to transport student.	-Communicate with school staff and parents/guardians any concerns, or adjustments that need to be made to this plan.

AUTHORIZATION / USE OF INFORMATION / 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:_____

I consent to the disclosure and use of the personal information collected herein to persons, including persons who are not the employees of the Limestone District School Board through the posting of photographs and medical information of my child (Plan of Care/Emergency Procedures) in the following key locations:

❒ classroom ❒ other: _____

❒ office

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

❒ ***Please note: Checked box indicates that this student has an additional Plan of Care***