York Region District School Board
Inspire Learning!

Date: ______________________________

EPILEPSY (Seizure Disorders) HEALTH CARE PLAN

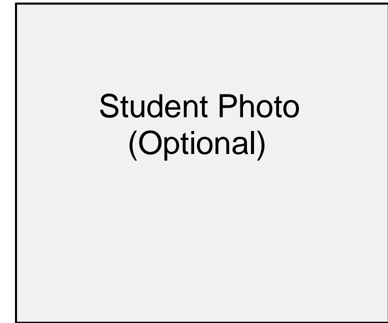
STUDENT INFORMATION

School: ____

Student Name:_________________ Date of Birth:__________

Age:_____ School:______________

Grade:______________ Teacher:______________



EMERGENCY PROCEDURES

ACT QUICKLY & RESPONSIVELY. THE FIRST SIGNS OF A SEIZURE CAN BE MILD, BUT SYMPTOMS CAN GET WORSE QUICKLY.

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.

EMERGENCY PROCEDURES
Students with epilepsy will typically experience seizures as a result of their medical condition.
Call 9-1-1 when:

- ❒ Convulsive (tonic-colonic) seizure lasts longer than___________minutes
- ❒ Student has repeated seizures without regaining consciousness
- ❒ Student has a first-time seizure
- ❒ Student has breathing difficulties
- ❒ Student has a seizure in water
- ❒ Notify parent(s)/guardian(s) or emergency contact

York Region District School Board
InspireLearning!

Date: ______________________________

KNOWN SEIZURE TRIGGERS
CHECK ALL THOSE THAT APPLY

❐Stress ❐Menstrual Cycle ❐Inactivity ❐Changes in Diet

❐Lack of Sleep ❐Improper Medication Balance ❐Illness

❐Electronic Stimulation (TV, Videos, Florescent Lights) ❐Changes in Weather

❐Other: ____

❐Any other Medical Conditions and/or Allergy?____________________________________

____

EMERGENCY CONTACTS (LIST IN PRIORITY)			
NAME	RELATIONSHIP	DAYTIME PHONE	ALTERNATE PHONE
1.			
2.			
3.			

DAILY/ROUTINE SEIZURE MANAGEMENT

Note: it is possible for a student to have more than one seizure type. Record information for each seizure type. (e.g., tonic-colonic, absence, simple partial, complex partial, atonic, myoclonic, and/or infantile spasms)

SEIZURE TYPE	PREVENTATIVE ACTIONS	ACTIONS TO TAKE DURING SEIZURE
Type: Description: Frequency of Seizure Activity: Typical Seizure Duration: Known Triggers:		
Type: Description: Frequency of Seizure Activity: Typical Seizure Duration: Known Triggers:		

Storage and location of spare medication and other supplies if applicable:

Date: ______________________________

____

____

Disposal of unused medication and medical supplies if applicable (supply and disposal of unused medication and/or medical supplies are facilitated by the family):

____

____

BASIC FIRST AID: CARE AND COMFORT

First Aid procedures:____

____

____

Does student needs 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

Date: ______________________________

AUTHORIZATION/PLAN REVIEW

INDIVIDUALS WITH WHOM THIS PLAN OF CARE IS TO BE SHARED

❒ School Staff

Other Individuals to be Contacted Regarding Plan of Care:

Before-School Program ❒Yes ❒No ______________________________

After-School Program ❒Yes ❒No ______________________________

School Bus Driver ❒ Route #: ______________________________

Other:______________________________

This plan remains in effect for the 20 — - 20 — school year without change and will be reviewed on or before:______________________________unless otherwise notified by parents of need to revisit the Plan. (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.)

I/We hereby request that the York Region District School Board, its employees or agents, as outlined, administer the above procedure to my/our child. The York Region District School Board employees are expected to support the student's daily or routine management, and respond to medical incidents and medical emergencies that occur during school, as outlined in board policies and procedures. Parent(s)/guardian(s) acknowledge that the employees of the York Region District School Board, who will administer the related procedures, are not medically trained. At all times it remains the responsibility of the parent(s)/guardian(s) to ensure that clear instructions and current physician's orders are provided to the principal.

Parent(s)/Guardian(s): ______________________________ Date: ____________________

Signature

Principal: ______________________________ Date: ____________________

Signature

Authorization for the collection of this information is in accordance with the *Education Act*, the *Municipal Freedom of Information and Protection of Privacy Act*, and the *Personal Health Information Protection Act*, as amended and applicable. The purpose is to collect and share medical information and to administer proper medical care in the event of an emergency or life-threatening situation. Users of this information include but are not limited to principals, teachers, support staff, volunteers, and bus drivers. This form will be kept for a minimum period of one calendar year. Contact person concerning this collection is the school principal.

Date: ______________________________

Distribution:	Original:	Secure location accessible by school staff
	Original:	Scanned and uploaded to SSNET
	Original:	Scanned and sent to Student Transportation Services
	Copy:	Parent/Guardian
	Copy:	File in the OSR

RETAIN: Current school year + 1 year

Relevant Forms:

Staff Administration of Medication Form
Self-Administration of Medication Form
Medical Incident Record Form (accessed via SSNET)