

**Epilepsy / Other Seizure Disorders**

**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)*

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

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.**