Dufferin-Peel Catholic District School Board

PLAN OF CARE – PREVALENT MEDICAL CONDITION
EPILEPSY OR OTHER SEIZURE DISORDER

ONCE COMPLETED, THIS FORM ONLY REQUIRES UPDATING IF THE STUDENT'S MEDICAL CONDITION CHANGES.

Student Information

Student Name: _____

Date of Birth: _____

DPCDSB Student Number: _____

Emergency Contact Information:

Name:	**Relationship:**	**Contact Numbers:**

Daily Routine Management: Epilepsy and other Seizure Disorders

TO BE COMPLETED BY MEDICAL PRACTITIONER OR HEALTH CARE PROVIDER

- ☐ Tonic-Clonic
- ☐ Absence
- ☐ Simple Partial
- ☐ Complex Partial
- ☐ Atonic
- ☐ Myoclonic
- ☐ Infantile spasms
- ☐ Other: _____

Convulsive Seizure

Convulsive seizure type: _____ Frequency of seizure activity: _____ Typical seizure duration: _____

Description of convulsive seizure: _____

Action to take during seizure: _____

Non-convulsive Seizure

Non-convulsive seizure type: _____ Frequency of seizure activity: _____ Typical seizure duration: _____

Description of non-convulsive seizure: _____

Action to take during seizure: _____

Has a rescue medication been prescribed? ☐ Yes ☐ No

Name of emergency rescue 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.

Special accommodations (if any): _____

Possible side effects: _____

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

Disposal of medication: _____

Medical Practitioner/ Healthcare Provider Name: _____ Profession/ Role: _____

Signature: _____ Date: _____

First Aid for Seizures

FIRST AID FOR NON-CONVULSIVE SEIZURES

Remain calm and note time/duration of the seizure. Stay with student and keep them safe. Do not restrain or interfere with movements. Move dangerous objects out of the way. Gently guide away from danger and block access to hazards.

As consciousness returns, speak to them in a soothing, reassuring way. They may be confused and disoriented, stay with them until complete awareness returns. Record in seizure log and notify parent(s)/guardian(s) that a seizure has occurred.

FIRST AID FOR CONVULSIVE SEIZURES

Remain calm and note time/duration of the seizure. Stay with student and keep them safe. Do not restrain or interfere with movements. Protect from injury. Move dangerous objects out of the way. If possible, ease the person to the floor and place something soft under their head. Do not put anything in mouth (other than rescue medication if prescribed).

As seizure subsides gently roll them to their side to help keep their airway clear. Speak to them in a soothing, reassuring way. They may be confused and disoriented, stay with them until reoriented. They may need rest/sleep after a Convulsive Seizure. Record in seizure log and notify parent(s)/guardian(s) that a seizure has occurred.

EMERGENCY RESPONSE

CALL 911 IMMEDIATELY IF:

- A convulsive seizure lasts longer than five (5) minutes.
- A seizure continues beyond the threshold time articulated in the Plan of Care.
- If student has breathing difficulties.
- If seizure returns without full recovery between seizures or if student is experiencing prolonged confusion.
- If student is injured during the seizure or has diabetes.
- If student has a seizure in water.

Notify parent(s) or guardian(s) or emergency contact.

ADMINISTRATIVE/PLAN REVIEW

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

☐ Principal or designate
☐ Classroom Teacher(s)
☐ Student Monitors/Volunteers
☐ Teacher in Charge
☐ Planning Time Teacher(s)
☐ Occasional Teachers
☐ Administrative Assistant(s)
☐ Resource Teacher(s)
☐ Support Services
☐ **ALL OF THE ABOVE**

Other individuals to be contacted regarding Plan of Care:

☐ PLASP and/or daycare ☐ Transportation ☐ Other: _____

Parent and Guardian Acknowledgement and Consent

As the parent of: _____, I have been an active participant in supporting the management of my child's medical condition(s) while they are 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 what 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 their medical condition.
- ☐ I have encouraged my child to self-manage and self-advocate.
- ☐ I give consent to share information on signs and/or 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.
- ☐ Emergency rescue medication will be stored in a central location.
- ☐ My child will carry their emergency rescue medication.

This plan remains in effect without change and will be reviewed annually.

It is the responsibility of the parent(s) or guardian(s) to notify the Principal if there is a need to change the Plan of Care.

Parent/ Guardian Signature: _____ Date: _____

Student Signature: _____ Date: _____

Principal Signature: _____ Date: _____