PREVALENT MEDICAL CONDITION EPILEPSY/SEIZURE DISORDER
PLAN OF CARE

STUDENT INFORMATION		Student Photo
Student Name:		
Student wears Medical-Alert Bracelet YES NO		
Date of Birth	Age:	
Teacher	Grade:	☐ I consent to publicly displaying this photo.

EMERGENCY CONTACTS in ORDER

Name	Relationship	Phone #
1.		
2.		
3.		
4.		

EMERGENCY RESCUE MEDICATION

Has an emergency rescue medication been prescribed? Yes No
If yes, the following section must be completed by a physician.

Name of Medication	
Method of Administration	Dosage: Time of Administration:
Additional Information	
Name of Physician (print)	
Phone Number	
Physician Signature	DATE:

KNOWN SEIZURE TRIGGERS (check all that apply)

☐ Stress ☐ Menstrual cycle ☐ Inactivity ☐ Excessive Activity	☐ Changes in Diet ☐ Lack of Sleep ☐ Electronic Stimulation ☐ TV ☐ Video ☐ Tablet/Phone ☐ Fluorescent Lights	☐ Heat/overheating ☐ Illness ☐ Change in Weather ☐ Improper Medication ☐ Other: _____

Does the student have any other Prevalent Medical Conditions for which there is a Plan of Care? No Yes
If Yes, check all that apply:

- ☐ Anaphylaxis
- ☐ Asthma
- ☐ Concussion
- ☐ Diabetes

DAILY MANAGEMENT

It is possible for a student to have more than one seizure type. Please record information for each seizure type.
Seizure type:

- ☐ Tonic-clonic
- ☐ Absence
- ☐ Simple partial
- ☐ Complex partial
- ☐ Atonic
- ☐ Myoclonic
- ☐ Infantile spasms
- ☐ Other

Frequency of Seizure activity: _____
Typical Duration of Seizure: _____

MANAGEMENT PLAN AT HOME

Frequency of Seizure Activity	
Typical Duration	
Medication Given at Home	
Describe Daily Home Management	

NCCSA EMERGENCY PROCEDURES FOR EPILEPSY/SEIZURE DISORDER

SEIZURE TYPE AND DESCRIPTION	
SEIZURE RESPONSE	☐ ☐ ☐ ☐ **IF SYMPTOMS CONTINUE, CALL 911**

BASIC FIRST AID: CARE AND COMFORT

- ☐ **Stay calm**
- ☐ **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**

HEALTH CARE PROVIDER INFORMATION

Please review this plan of care with your healthcare provider.

Name:	Profession ☐ Physician ☐ Nurse practitioner	Medication: Name: Dosage: Frequency:

Special Instructions:

Signature (where possible):	Date:

INDIVIDUALS with whom THIS PLAN OF CARE WILL BE SHARED

- ☐ **I/we authorize the principal to share the Plan of Care with school staff who are in direct contact with my child.**
- ☐ **I/we authorize the following to also have access to this Plan of Care (check all that apply)**
  - ☐ **Niagara Children's Centre**
  - ☐ **Before and/or After School Program**
  - ☐ **Transportation Provider**
    - ☐ **BUS # _____**

This plan of care remains in effect for the _____ School Year and will be reviewed within the first 30 days of a new school year
If at that time, there are no changes to the student medical history, this information may remain on file.
It is the responsibility of parents to notify the principal if there is a need to change this plan during the school year.

Parent Signature:	Date:
Student Signature:	Date:
Principal Signature:	Date: