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 medication been prescribed to manage this condition? Yes No
Has emergency recovery medication been prescribed? Yes No

If yes, this plan must be shared with your physician and the following section (appendix A) must be completed by a physician.

NCCSA AUTHORIZATION OF PROVISION OF ORAL/TOPICAL Prescription MEDICATION

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: _____

STUDENT NAME:

Does the student have any other Prevalent Medical Conditions for which there is a Plan of Care?

Yes No

If Yes, check all that apply:

- ☐ Anaphylaxis
- ☐ Asthma
- ☐ Diabetes
- ☐ Concussion
- ☐ General: _____

SEIZURE INFORMATION

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

SCHOOL NOTES REGARDING ADMINISTRATION OF RESCUE MEDICATION

To be completed by the Principal and Parent when consulting about the Plan of Care.

STUDENT NAME:	
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**

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 are aware that the school will share this Plan of Care with:**
  - ☐ **Niagara Children's Centre**
  - ☐ **Nursing (if applicable)**
  - ☐ **Transportation Provider**

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:

Appendix A

niagara children's centre school Weaving education and therapy together for student success.
AUTHORIZATION OF PROVISION OF ORAL/TOPICAL PRESCRIPTION MEDICATION
TO BE COMPLETED BY PARENT/GUARDIAN

STUDENT NAME		
BIRTHDATE		**GRADE**
ADDRESS		**PHONE NUMBER**
PARENT NAME		

HEALTH CARE PROVIDER INFORMATION
Please review the NCCSA Plan of Care with your healthcare provider.

Provider Name	Provider Address and Phone Number	☐ Physician ☐ Nurse Practitioner
Special Instructions from Health Care Provider		

Name of Medication	
DATE	
Date prescribed	
Dosage to be provided each time	
Times dosage to be provided	
Method of administration	
Possible side effects	
Storage and safekeeping s	

PARENT/GUARDIAN APPROVAL
I hereby request and give permission to NCCSA to provide Oral/topical prescription medication to my child according to NCCSA procedures and the instructions provided.
I also affirm that the medication provided is the medication stated on the container provided to the school.

Signature of Health Care Provider **Optional** UNLESS medication is rescue medication.		
Signature of Parent/Guardian		DATE: