|  |  |  |
| --- | --- | --- |
|  **1. STUDENT PROFILE and INFORMATION** | **Date Completed:** | YYYY-MM-DD |
| **Student Name** |  | **Birth Date** | YYYY-MM-DD | **Age** | 00 |
| **Current School** |  | **Current Grade** | 00 | **OEN** | 000-000-000 |
| **Teacher(s)** |  |
| **Parent/Guardian** |  | **Phone** |  |
| **Other Medical Conditions or Allergies** |  |

|  |  |
| --- | --- |
| **2. EMERGENCY CONTACTS** | Listed in priority: |
|  | **Name** | **Relationship to Student** | **Preferred Phone** | **Alternate Phone** |
| **1** |  |  |  |  |
| **2** |  |  |  |  |
| **3** |  |  |  |  |

|  |
| --- |
| **3. EMERGENCY RESCUE MEDICATION** |
| **Has the student been prescribed an emergency rescue medication?**  |  **YES** [ ]  | **NO** [ ]  |
| If YES, attach the rescue medication plan, healthcare providers’ orders and authorization from the students’ parents/guardians 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. |

|  |  |
| --- | --- |
| **4. KNOWN SEIZURE TRIGGERS** | Check all that apply: |
| [ ]  Stress | [ ]  Changes in diet | [ ]  Illness |
| [ ]  Change in weather | [ ]  Mensural cycle | [ ]  Lack of sleep |
| [ ]  Improper medication balance | [ ]  Inactivity | [ ]  Electronic stimulation (video, lights) |
| [ ]  Other:  | [ ]  Other: | [ ]  Other: |

|  |
| --- |
| **5. DAILY ROUTINE EPILEPSY MANAGEMENT**  |

|  |  |
| --- | --- |
| **Description of Non-convulsive Seizure** | **Action** (e.g., trigger avoidance, dietary therapy, risks to mitigate) |
|  |  |
| **Description of Convulsive Seizure** | **Action** |
|  |  |

|  |  |
| --- | --- |
| **6. SEIZURE MANAGEMENT**  |  |

|  |  |
| --- | --- |
| **Seizure Type** (e.g., tonic-clonic, absence, etc.) |  |
| **Seizure description** |  |
| **Actions to take during seizure** |  |
| **Frequency of seizure**  |  | **Typical seizure duration** |  |

*As a person may have more than one seizure type, record information for additional type(s) below. Duplicate this section as needed.*

|  |  |
| --- | --- |
| **Seizure Type** (e.g., tonic-clonic, absence, etc.) |  |
| **Seizure description** |  |
| **Actions to take during seizure** |  |
| **Frequency of seizure**  |  | **Typical seizure duration** |  |
| **7. BASIC FIRST AID: CARE and COMFORT**  |

|  |
| --- |
| **First Aid Procedures** |
|  |
| **Does the student need to leave the classroom after a seizure episode?** |  **YES** [ ]  |  **NO** [ ]  |
| If YES, describe the process for returning the student to the classroom below: |
|  |
| **BASIC SEIZURE FIRST AID** | **FOR TONIC-CLONIC SEIZURE EPISODES:** |
| * Stay calm and track time/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
 | * Protect student’s head
* Keep airway open/watch breathing
* Turn student on side
 |

|  |
| --- |
| **8. EMERGENCY PROCEDURES**  |

|  |
| --- |
| Students with epilepsy will typically experience seizures as a result of their medical condition.**Call 911 when:*** Convulsive (tonic-clonic) seizure lasts longer than five minutes.
* Student has repeated seizures without regaining consciousness.
* Student is injured or has diabetes.
* Student has breathing difficulties.
* Student has a seizure in water.

Notify parents/guardians or the emergency contacts in Section 2. |
| **9. PARENT PRE-AUTHORIZATION and CONSENT FOR EPILEPSY INTERVENTIONS** |
| **Student Name** |  | **Birth Date** | YYYY-MM-DD | **Age** | 00 |
| **Current School** |  | **Current Grade** | 00 | **OEN** | 000-000-000 |
| **Parent/Guardian** |  | **Phone** |  |
| **Address** |  |

|  |
| --- |
| **Consent to release and share information\*:** I/we authorize and provide consent to school staff to use and/or share information in this plan for purposes related to the education, health, and safety of my/our child. This may include: 1. Displaying my/our child’s photograph and/or additional information on paper notices or electronic formats(s) so that staff, volunteers, and school visitors will be aware of my/our child’s medical condition
2. Communicating with bus operators
3. Sharing information in special circumstances to protect the health and safety of my/our child.
 |
| **Consent to transfer to hospital:** I/we consent in advance to my/our child’s being transported to a hospital if required, based on the judgement of school staff. I/we also permit a staff member to accompany my child during transport. I/we agree that the school’s administrator or designate shall decide if an ambulance is to be called, and to assume responsibility for all costs associated with any medical intervention. |
| **Consent to treatment:** I/we am aware that school staff are not medical professionals and perform all aspects of this plan to the best of their abilities and in good faith. I/we approve of the management steps and responses outlined in this care plan. |
| **Consent for annual review:** I am/we are aware that school staff will request my/our involvement in an annual review of this management plan, and when requirements change significantly, they will request my/our involvement in completing a new plan. |
| **Parent/Guardian (Print):** |  |
| **Parent/Guardian Signature(s):** |  |
| **Date Signed:** |  |

|  |  |
| --- | --- |
| **School Administrator Signature:** |  |
| **Date Signed:** |  |