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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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** | |  | | | | | | |

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

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| **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. | | |

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| **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: |

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

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

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| **6. SEIZURE MANAGEMENT** |  |

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| **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** | | | | |

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| **First Aid Procedures** | | | |
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| **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 | | |

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| **8. EMERGENCY PROCEDURES** |

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| 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** |  | | | | | |

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| **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:** |  |

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