NIAGARA CATHOLIC DISTRICT SCHOOL BOARD

INDIVIDUAL STUDENT EPILEPSY PLAN OF CARE

November 2022

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:

**This information is being collected pursuant to the provisions of the Municipal Freedom of Information and Protection of Privacy Act and under the Authority of the Education Act and will be used by Student Support. Questions about this collection should be directed to the Superintendent of Education – Student Support, Niagara Catholic District School Board, 427 Rice Road, Welland, Ontario L3C 7C1, 905-735-0240.*

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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**

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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.

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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: _____

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