UPPER GRAND DISTRICT SCHOOL BOARD

EPILEPSY/SEIZURE DISORDER
Plan of Care

518-4

STUDENT INFORMATION

Insert Photo

Student Name _____ Date of Birth _____

Ontario Ed #(OEN) _____ Age _____

Grade _____ Teacher(s) _____

Any other medical condition/ allergy _____

MedicAlert® ID ☐ Yes ☐ No

EMERGENCY CONTACTS (LIST IN PRIORITY)

NAME	RELATIONSHIP	DAYTIME PHONE	ALTERNATE PHONE
1.			
2.			
3.			

Has an emergency rescue medication been prescribed? ☐ Yes ☐ No
If yes, attach the rescue medication plan, healthcare providers' orders and authorization from the student's parent(s)/guardian(s) 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 or Epilepsy Educator (PPM 161).

KNOWN SEIZURE TRIGGERS

CHECK (✓) ALL THOSE THAT APPLY

☐ Stress
☐ Menstrual Cycle
☐ Inactivity
☐ Changes In Diet
☐ Lack Of Sleep
☐ Electronic Stimulation (TV, Videos, Florescent Lights)
☐ Illness
☐ Improper Medication Balance
☐ Change In Weather
☐ Other _____

DAILY/ROUTINE EPILEPSY/SEIZURE DISORDER MANAGEMENT	
DESCRIPTION OF SEIZURE (NON-CONVULSIVE)	**ACTION:**
	(e.g. description of dietary therapy, risks to be mitigated, trigger avoidance.)
DESCRIPTION OF SEIZURE (CONVULSIVE)	**ACTION:**

SEIZURE MANAGEMENT	
Note: It is possible for a student to have more than one seizure type. Record information for each seizure type.	
SEIZURE TYPE	**ACTIONS TO TAKE DURING SEIZURE**
(e.g. tonic-clonic, absence, focal aware seizure, focal impaired awareness seizure, atonic, myoclonic, infantile spasms) Type: _____ Description: _____	

Frequency of seizure activity: _____

_____

Typical seizure duration: _____

BASIC FIRST AID: CARE AND COMFORT

First aid procedure(s): _____

_____

Does student need to leave classroom after a seizure? ☐ Yes ☐ No

If yes, describe process for returning student to classroom: _____

_____

BASIC SEIZURE FIRST AID

- Stay calm and 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

Make necessary accommodations to seating arrangements, rest periods and testing for student safety and wellbeing.

EMERGENCY PROCEDURES

Students with epilepsy will typically experience seizures as a result of their medical condition.

Call 9-1-1 when:

- Convulsive (tonic-clonic) seizure lasts longer than five (5) minutes.
- Student has repeated seizures without regaining consciousness.
- Student is injured or has diabetes.
- Student has a first-time seizure.
- Student has breathing difficulties.
- Student has a seizure in water

*Notify parent(s)/guardian(s) or emergency contact.

HEALTHCARE PROVIDER INFORMATION (OPTIONAL)

Healthcare provider may include: Physician, Nurse Practitioner, Registered Nurse, Pharmacist, Respiratory Therapist, Certified Respiratory Educator, or Certified Asthma Educator.

Healthcare Provider's Name: _____

Profession/Role: _____

Signature: _____ Date: _____

Special Instructions/Notes/Prescription Labels:

If medication is prescribed, please include dosage, frequency and method of administration, dates for which the authorization to administer applies, and possible side effects.
✸This information may remain on file if there are no changes to the student's medical condition.

AUTHORIZATION/PLAN REVIEW

INDIVIDUALS WITH WHOM THIS PLAN OF CARE IS TO BE SHARED

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

INSTRUCTIONS FOR TRANSPORTATION PROVIDER

Is the student a bus student? ☐ No ☐ Yes* **NOTE**: Bus drivers do not have access to the Plan of Care and provide limited care.

***SEE NEXT PAGE FOR BUS PROCEDURES**

_____

This plan remains in effect for the 20___— 20___ school year without change and will be reviewed on or before: _____ (It is the parent(s)/ guardian(s) responsibility to notify the principal if there is a need to change the plan of care during the school year.)

Parent(s)/Guardian(s): _____ Date: _____
Signature

Student: _____ Date: _____
Signature

Principal: _____ Date: _____
Signature

EPILEPSY/SEIZURE DISORDER PLAN OF CARE – Instructions for Transportation Provider

1. Bring the bus to a stop in a safe location
2. Notify dispatch to call 9-1-1
   a. After calling 9-1-1, dispatch will call the school/principal to notify parent/guardian or emergency contact
3. For Tonic-Clonic (convulsive) seizure:
   a. Protect student's head (e.g. put something soft under their head)
   b. Keep airway open and watch breathing
   c. Turn student on side
4. Basic seizure first aid:
   a. Stay calm and track time and duration of seizure
   b. Keep student safe
   c. Do not restrain or interfere with student's movements
   d. Do not put anything in student's mouth
   e. Stay with student until fully conscious
5. Bus drivers are unable to administer any rescue medication. If it is required, it will be administered by EMS.

Student-specific instructions for bus driver must include:

- What are known seizure triggers?
- If an emergency rescue medication has been prescribed, where is it kept with the student while on the bus (e.g., specific pocket in backpack)?
- Seizure type, description and actions to be taken during a seizure
- Frequency of seizure activity and typical duration

Transportation Services Acknowledgement by Parent/Guardian of Bus Student

I understand that student transportation is a service provided by the board to eligible students and is not a right or entitlement.

I acknowledge that the school bus driver's primary responsibility is the safe operation of the vehicle and the safety of all passengers. I understand that drivers are not medical professionals and cannot provide ongoing medical supervision while driving.

In the event of a medical concern or emergency, I understand that the driver will follow established procedures, which may include safely stopping the bus and contacting emergency services. I acknowledge that while every effort will be made to respond to my child's medical needs, the level of response may be limited by the driver's responsibility to maintain the safety of all passengers.

I confirm that I have provided all relevant medical information and supports required for my child's safe transportation, as outlined in this Plan of Care.

Parent/Guardian Initials: _____ Date: _____