RIM	
Board Form	Board Form No.
Student Services	S.16C-206
Classification	Retention
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YORK CATHOLIC DISTRICT SCHOOL BOARD

EPILEPSY PLAN OF CARE & CONSENT FORM

EPILEPSY
Plan of Care

STUDENT INFORMATION

Date Created _____ Bus Route/# _____

Student Name _____ Date Of Birth _____

Age _____ School _____

Grade _____ Teacher(s) _____

Other medical condition/allergy? MedicAlert® ID ☐ Yes ☐ No

_____

Insert Photo

Student Photo (optional)

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

DAILY/ROUTINE EPILEPSY/SEIZURE MANAGEMENT

DESCRIPTION OF SEIZURE	ACTION:
	(e.g. description of dietary therapy, risks to be mitigated, trigger avoidance.)

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: _____

Action Plan for supporting school access (e.g.: access on the stairs, transition between classes, toileting routines:

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.

* At the discretion of the school 911 may be called.

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._____

Other Individuals To Be Contacted Regarding Plan Of Care:

Before-School Program ☐ Yes ☐ No _____

After-School Program ☐ Yes ☐ No _____

School Bus Driver/Route # (If Applicable) _____

Other:_____

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

Consent Form (Self-Administer and/or Employee Administer)

To Carry and Administer Medication for a Prevalent Medical Condition

CONSENT FORM
TO CARRY AND ADMINISTER MEDICATION / DISCLOSE PERSONAL INFORMATION

TO BE SIGNED BY PARENT/GUARDIAN UNLESS THE STUDENT IS 18 YEARS OF AGE OR OLDER

ADMINISTRATION OF MEDICATION

In the event of my child _____ experiencing a medical emergency, I consent to the administration of _____(specify type of medication) by an employee of the _____(school board) as prescribed by the physician and outlined in the Emergency Procedures of the Prevalent Medical Conditions Policy/Administrative Procedure.

PLEASE PRINT
Student's Name: _____ Class/Teacher: _____

Name of Parent/Guardian: _____

Signature of Parent/Guardian:_____ Date: _____

Signature of Student: _____ Date: _____
(if 18 years of age or older)

MAINTENANCE OF MEDICATION

I understand that it is the responsibility of my child _____to carry

_____(specify type of medication) on his/her person.

PLEASE PRINT
Student's Name: _____ Class/Teacher: _____

Name of Parent/Guardian: _____

Signature of Parent/Guardian:_____ Date: _____

Signature of Student: _____ Date: _____
(if 18 years of age or older)

Name of Physician: _____ Physician Phone #: _____

COLLECTION, DISCLOSURE AND USE OF PERSONAL INFORMATION

Personal information on this form is collected under the authority of the Education Act and s. 28(2) of the Municipal Freedom of Information and Protection of Privacy Act (MFIPPA). It will be used to develop and administer the student's emergency Plan of Care and may be shared with authorized YCDSB staff and emergency responders as necessary. Questions about this collection should be directed to the Principal of the school.

OPTIONAL:

Additionally, I further consent to the disclosure and use of the personal information collected herein to persons, including persons who are not the employees of the _____ (School Board) through the posting of photographs and medical information of my child (Plan of Care/Emergency Procedures) in the following key locations:

❒ classroom ❒ staffroom ❒ lunchroom ❒ other

❒ office ❒ school bus ❒ gym

and through the provision of personal information contained herein to the following persons who are not employees of the Board: please check (✓) all applicable boxes

❒ Food service providers ❒ Child care providers

❒ Board approved transportation carriers ❒ Other _____

❒ School volunteers in regular direct contact with my child

Signature of Parent/Guardian:_____ Date: _____

Signature of Student: _____ Date: _____
(if 18 years of age or older)

Signature of Principal: _____ Date: _____

If medication is prescribed, please include dosage, frequency and method of administration, dates for which the authorization to administer applies, and possible side effects.

PLEASE NOTE THIS CONSENT EXPIRES AT THE END OF THE CURRENT SCHOOL YEAR.