FORM Nbr: SA 10115
DATE: June/19

PREVALENT MEDICAL CONDITION-EPILEPSY
PLAN OF CARE

STUDENT INFORMATION

Student Photo

Student Name _____ Date of Birth_____

Ontario Ed #_____ Age_____

Grade_____ Teacher_____

EMERGENCY CONTACTS (LIST IN PRIORITY)

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

KNOWN SEIZURE TRIGGERS – (check all 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 _____
❒ Any Other Medical Condition or Allergy? _____

ADMINISTION OF EMERGENCY SEIZURE MEDICATION

Use _____in the dose of_____ when the seizure lasts for _____minutes
(Name of medication)

INSTRUCTIONS FOR MANAGING A SEIZURE

Basic Seizure First Aid

□ Stay calm & time the duration of the seizure
□ Keep child safe
□ Do not restrain the child
□ Do not put anything in the child's mouth
□ Stay with the child until he/she is fully conscious
□Protect the child's head
□Keep airway open/monitor breathing
□Keep child on his/her side

EMERGENCY RESPONSE

CALL 911 IF:

The seizure lasts more than ____ minutes or if the child is in respiratory distress.

Administer Emergency Seizure Medication if needed

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HEALTHCARE PROVIDER INFORMATION

Healthcare provider may include: Physician or Nurse Practitioner

Healthcare Provider's Name:_____
Profession:_____
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