

DAILY/ROUTINE EPILEPSY 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. absence (petit mal), atonic, clonic, myoclonic, tonic, tonic-clonic (grand mal), simple partial, complex partial, 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 (unless directed on the action plan e.g. administration of sublingual medication)
- Stay with student until fully conscious

FOR TONIC-CLONIC SEIZURE:

Protect student's head

Watch breathing (turn student on side, assists with keeping the airway open)

Turn student on side

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. _____

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).

Physician: _____ Date: _____
Signature

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

Student: _____ Date: _____
Signature

Principal: _____ Date: _____
Signature