OTTAWA-CARLETON
DISTRICT SCHOOL BOARD

# OCDSB 963: PLAN OF CARE FOR STUDENTS WITH EPILEPSY/SEIZURE DISORDER

(References: **P.108.SCO**, **PR.548.SCO**, and **PR.547.SCO**)

The information on this form is collected annually and deemed valid until August 31 of each school year.

**Student Information** (Attach a recent photo of student)

- Student Name (first, middle, last):
- Student Date of Birth:
- School Name:
- Grade:
- Student Number:
- Teacher Name:

**Parent/Guardian Information** (required if student is under 18 years of age)

- Parent/Guardian First and Last Name :
- Home Phone Number:
- Parent Email Address:

**Emergency Contacts** (Please list in order of priority)

| Name | Relationship | Daytime Phone | Alternate Phone | Email |
|---|---|---|---|---|
| 1. | | | | |
| 2. | | | | |
| 3. | | | | |

**Primary Healthcare Provider Information**

- Name:
- Telephone number:
- Profession/Role:

**Epilepsy/Seizure Disorder Specialist Information**

◯ Same as Primary Healthcare Provider.

◯ Different from Primary Healthcare Provider (Complete the following information)

- Name:
- Telephone number:
- Profession/Role:
  - ◯ Physician
  - ◯ Nurse Practitioner
  - ◯ Registered Nurse
  - ◯ Pharmacist
  - ◯ Respiratory Therapist
  - ◯ Certified Respiratory Educator
  - ◯ Certified Asthma Educator
  - ◯ Other. Please specify:

☐ **I/We authorize the school staff to contact the above health care provider as required to attend to the well-being of the student.**

**Please attach the most recent, original instructions, prescriptions, and labels pertaining to each medication. Date of prescription/notes must be captured.**

## Daily Routine for Epilepsy/Seizure Disorders Management

**KNOWN SEIZURE TRIGGERS** (check all that apply)

☐ Change in Weather

☐ Changes in Diet

☐ Electronic Stimulation (TV, Videos, Fluorescent Lights)

☐ Hormonal fluctuations

☐ Illness

☐ Improper Medication Balance

☐ Inactivity

☐ Lack of sleep

☐ Stress

☐ Any other medical condition or allergy?

☐ Other triggers:

**Please complete as applicable**

| Type of Seizure | Symptoms | Action to Take (e.g. description of dietary therapy, risks to be mitigated, trigger avoidance) | Frequency of Seizure Activity (daily, monthly, or annually) | Typical Seizure Duration | Date of Last Seizure |
|---|---|---|---|---|---|
| Non-Convulsive Seizure | | | | | |
| Convulsive Seizure | | | | | |
| Other. Please list type | | | | | |

**OTHER ACCOMMODATION** (e.g. during nutrition breaks, field trips, protective equipment, post-incident care)

**Emergency Procedures FIRST AID**

**PROCEDURE**

## Medication

**Has a routine or rescue medication been prescribed to the student?**

- ◯ Yes.
- ◯ No.

## Medication Details

- Name of medication:
- Prescription Number:
- Dosage of Medication:
- Time of Administration:
- Instructions for Administration:
- Duration of Medication Regime:
- Possible Side Effects:

**Do you authorize the student to carry the required medication at all times?**

- ◯ Yes. The medication is kept in the student's:
  - ◯ Pocket
  - ◯ Case/pouch
  - ◯ Backpack/fanny pack
  - ◯ Other (specify)

◯ No. Please specify where medication is kept (e.g. name of an individual or locker combination):

Please specify location of **backup medication** in school:

Storage requirements (if any):

Disposal Instructions:

☐ **I/We acknowledge that it is my/our responsibility to submit enough backup medication to school and to track the expiration date.**

**Parent(s)/Guardian(s) Authorization to Administer Prescribed Medication**

The administration of medication involves certain elements of risk, including, but not limited to illness, adverse reactions or other complications. Reactions caused by the administration of any medication can occur without fault on any party, including the student, or the OCDSB or its employees or agents. By requesting and consenting to the administration of medication by an employee of the OCDSB, or by authorizing the self-administration of medication by the student, you are assuming any associated risks.

**In life-threatening emergencies**, staff will administer prescribed medication to students "in loco parentis", not as healthcare professionals.

☐ I/We authorize the OCDSB staff to administer prescribed medication to the student as prescribed. I/We understand that OCDSB staff is not medically trained to administer medication and bear sole responsibility for any adverse reaction that might occur following the administration of medication.

☐ The student is capable of administering their own medication. I/We bear sole responsibility for any adverse reaction that might occur following the self-administration of medication.

**Consent to Release Information**

**Does the student use OSTA bus on a regular basis?**

◯ Yes. A copy of the Student Care Plan will be shared with OSTA.

◯ No.

☐ I/We give consent for the school to share this Plan of Care as necessary with individuals in direct contact with the student to attend to their well-being and medical needs at school and during school activities. This may include school and office staff, occasional staff, OSTA, contracted bus operators and bus drivers, before- and after-school program staff. This plan will be posted in identified areas of the school for emergency response purposes.

☐ I confirm that the information herein is accurate and up to date. I understand that I must re-submit this form in case of any changes to the student's medication, condition, level of independence, or treatment plan.

Parent(s)/guardian(s)/Adult Student Name:

Parent(s)/guardian(s)/Adult Student signature:

Date:

*The personal information of this form is collected under the authority of the Education Act (RSO. 1990 c.E.2) and in accordance with the Municipal Freedom of Information and Protection of Privacy Act (RSO. 1990 c.M56), as amended. It will be used to establish the Ontario Student Record [OSR] and for student and education related purposes such as registration, administration, communication, collection of fees, data reporting, and Student Transportation Services. In addition, the information may be used or disclosed to comply with legislation, for compelling circumstances affecting health and safety or discipline, as required in circumstances related to allow enforcement matters, and with third parties in accordance with established service agreements or in accordance with any other Act. Questions or concerns should be directed to the school principal or the Board's Freedom of Information Coordinator, Ottawa-Carleton District School Board, 133 Greenbank Road, Ottawa, Ontario, K2H 6L3, Telephone 613-596-8211 ext. 8607.*