APPLEBY COLLEGE

EPILEPSY – PLAN OF CARE

STUDENT INFORMATION

Student's First Name ___________________________

Student's Last Name ___________________________

Date of Birth __________________________________

Student Photo
(please attach)

EMERGENCY CONTACTS (LIST IN PRIORITY)

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

Please list medication(s) student is currently taking: _____________________________________

____

Has an emergency rescue medication been prescribed? ❐ Yes ❐ No

If yes, please provide us with a rescue medication plan.

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 or Fever

❐ Improper medication balance

❐ Change in weather

❐ Other ____

❐ Any other medical condition or allergy? ____

DAILY ROUTINE AND SEIZURE MANAGEMENT

TYPE OF SEIZURE	DESCRIPTION OF SEIZURE (Frequency, duration, key characteristic, sensory signs, trigger)	ACTION: (risks to be mitigated, trigger avoidance, actions to take during/following seizure, list medication)

BASIC FIRST AID: CARE AND COMFORT

BASIC SEIZURE FIRST AID

- Stay calm. 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

Additional first aid procedure(s): ____

____

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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

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

Healthcare Provider's Name: ____

Profession: ____

Signature (optional): ______________________ Date: ______________________

Special Instructions/Notes/Prescription:

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.

ADDITIONAL NOTES

Please include any additional notes here.

AUTHORIZATION/PLAN REVIEW

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