

HAMILTON-WENTWORTH CATHOLIC DISTRICT SCHOOL BOARD



Believing, Achieving, Serving

**EPILEPSY
MANAGEMENT PLAN**

Revised
AUGUST 2019



HAMILTON-WENTWORTH CATHOLIC DISTRICT SCHOOL BOARD

ADULT STUDENT/PARENT/GUARDIAN
REQUEST AND CONSENT
FOR
EPILEPSY INTERVENTIONS

Student's Name: _____ O.E.N: _____

Birthdate: _____ School: _____
(Year/Month/Day)

Address: _____
(Street) (City) (Postal Code)

Please fill out if you are the parent or guardian:

I/We _____ / _____,

the parents/guardians of _____ understand that:
(Name of Student)

- the principal, teachers and other school staff are not health care professionals and have no more information about the medical condition of my/our child than that which has been provided to them in writing by myself/ourselves or by my/our child's doctor. They are not experts in recognizing the symptoms of my/our child's medical condition or in treating it;
- to the extent possible, my/our child has been trained by me/us and by health care professionals, to recognize her/his own need for intervention/medication and to respond to the need by requesting intervention or by self-administering the appropriate medication;
- where feasible, my/our child is responsible for the necessary medication to address the epileptic condition.

Please fill out if you are an Adult Student:

I _____ understand that:

- the principal, teachers and other school staff are not health care professionals and have no more information about my medical condition than what has been provided to them in writing by myself or by my doctor. They are not experts in recognizing the symptoms of my medical condition or in treating it;
- to the extent possible, I have been trained by my health care professionals, to recognize my own need for intervention/medication and to respond to the need by requesting intervention or by self-administering the appropriate medication;
- where feasible, I am responsible for the necessary medication to address the epileptic condition.

- I/we are responsible for ensuring that –
 - all medical updates/changes or emergency information will be provided for the school staff immediately;
 - the teacher will be instructed concerning the incidents relating to seizures about which I/we wish to be informed.

- The specific incidents related to seizures about which I/we would like to be informed are:
 - _____
 - _____
 - _____
 - _____
 - _____

In the event of an emergency (a seizure lasting more than 5 minutes), I/we authorize the school staff to obtain emergency services and to authorize such emergency treatments as are necessary. I/We agree to assume responsibility for all costs associated with the medical intervention.

I/We give permission to the school staff to post the Individual Epilepsy Action Plan, with a picture of myself and/or of my/our child, in appropriate locations within the school.

I/We have reviewed and agree to the Epilepsy Management Plan for myself and/or my/our child.

Adult Student/Parent/Guardian Name: _____

Adult Student/Parent/Guardian’s Signature: _____

Date: _____
 (Year) (Month) (Day)

HAMILTON WENTWORTH CATHOLIC DISTRICT SCHOOL BOARD

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION- PHYSICIAN/NURSE PRACTITIONER FORM

Part I To be completed by the attending physician when medication is initiated or changed.

(Please type or print)

Student's Name: _____ Birthdate: _____

Address: _____ School: _____

This is to advise that I have prescribed the administration of the following medication listed below for those days when the above-mentioned student is in school:

1. Name of Medication _____
Method of Administration _____
Dosage _____ Time(s) _____
2. Expected date of discontinuation: _____
3. Must the medication be taken during school hours? _____
4. Contra-indications to giving medication: _____
5. Please specify possible hazards or side effects of medication:

6. Action to be taken should a reaction occur: _____

7. Allergies which should be noted (if applicable): _____

8. Additional instructions (e.g., storage of medication, etc.):

Physician's Name: _____ Telephone: _____

Address: _____

Physician's Signature: _____ Date: _____

HAMILTON-WENTWORTH CATHOLIC DISTRICT SCHOOL BOARD

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION- ADULT STUDENT/PARENT/GUARDIAN FORM

PART II -To be completed by Adult Student/Parent/Guardian when medication is initiated, changed, and annually at the beginning of each new school year.

This is to authorize the administration of the medication(s) prescribed by the attending physician/nurse practitioner from _____ to _____ for:

date date

Student's Name: _____ **Birthdate: (yyyy/mm/dd)** _____

School: _____

Medic Alert I. D.: Yes _____ No _____

- I give permission for my child to self-administer the medication prescribed by the attending physician. Yes ___ No ___

Signature of Parent/Guardian: _____

Date: _____
(Year, Month, Day)

- I release and agree to indemnify the Hamilton-Wentworth Catholic District School Board and its staff from any liability or damages incurred by any party as a consequence of the administration or lack of administration of medication to myself or my child.

Signature of Parent/Guardian/Adult Student: _____

Date: _____
(Year, Month, Day)

NOTE:

- Parents/guardians/adult students are requested to PLACE MEDICATION IN INDIVIDUAL CONTAINERS, preferably those in which the medication was supplied from the pharmacist/physician.
- The containers should be PROPERLY LABELLED indicating the NAME of MEDICATION, STUDENT'S NAME, AND ADMINISTRATION DIRECTIONS.
- The medication will be delivered by parent/guardian/adult student, according to an agreed schedule, to the Principal or designated person for safe keeping, unless otherwise determined.

In case of EMERGENCY, the contact persons are:

Name _____ Name _____

Telephone _____ Telephone _____

Relationship _____ Relationship _____

Under The Municipal Freedom of Information and Protection of Privacy Act, 1989, information in forms and documents pertaining to a student registered/enrolled within The Hamilton-Wentworth Catholic District School Board is collected under the legal authority of The Education Act, and its Regulations, and the Ontario Student Record (O.S.R.) Guideline, 1989. This information is being collected to ensure that the educational program which is provided meets your child's needs.



INDIVIDUAL EPILEPSY PLAN OF CARE

STUDENT INFORMATION

Student Name _____ Date Of Birth _____

Ontario Ed. # _____ Age _____

Grade _____ Teacher(s) _____

Student Colour Photo

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.

KNOWN SEIZURE TRIGGERS

CHECK (✓) ALL THOSE THAT APPLY

- | | | |
|--|--|--|
| <input type="checkbox"/> Stress | <input type="checkbox"/> Menstrual Cycle | <input type="checkbox"/> Inactivity |
| <input type="checkbox"/> Changes In Diet | <input type="checkbox"/> Lack Of Sleep | <input type="checkbox"/> Electronic Stimulation
(TV, Videos, Florescent Lights) |
| <input type="checkbox"/> Illness | <input type="checkbox"/> Improper Medication Balance | |
| <input type="checkbox"/> Change In
Weather | <input type="checkbox"/> Other _____ | |
| <input type="checkbox"/> Any Other Medical Condition or Allergy? _____ | | |

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. tonic-clonic, absence, simple partial, complex partial, atonic, myoclonic, infantile spasms) Type: _____ Description: _____	

Frequency of seizure activity: _____

Typical seizure duration: _____

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

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.

Refer to Appendix L – Policy Manual – Student Miscellaneous - S.M.19 Epilepsy

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

	Yes (Please Initial for each)	No (Please Initial for each)
We, the Parents/Guardians/ Adult Student request the posting of this Individual Plan of Care in the:	School Staff Room	
	Elementary Homeroom Classroom	
	School Main Office	
We the Parents/Guardians/Adult Student request the sharing of this plan with individuals which include, but are not limited to classroom teachers, occasional teachers, itinerant teachers, educational assistants, coaches, other school staff, and school bus drivers.		
We the Parents/Guardians/ Adult Student request the sharing of information on signs and symptoms of Epilepsy with students in the classroom.		
We, the Parents/Guardians/ Adult Student request the sharing of this Individual Plan of Care with the Before and After-School Program.		
We the Parents/Guardians/Adult Student consent to the carrying of the medication on his/her person.		
We the Parents/Guardians/Adult Student consent to the self-administration of medication.		

TRANSPORTATION

School Bus Driver/Route # (If Applicable) New Plan of Care Updated Plan of Care

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:
Adult Student:	Date:
Principal:	Date:

HAMILTON-WENTWORTH CATHOLIC DISTRICT SCHOOL BOARD

INDIVIDUAL STUDENT LOG OF ADMINISTERED MEDICATION



NAME OF STUDENT: _____

BIRTHDATE: _____

Year Month Day

ADDRESS: _____

TELEPHONE: _____

SCHOOL: _____

PRINCIPAL: _____

MEDICATION	DESCRIPTION OF MEDICATION (pill, liquid, colour, etc.)	METHOD OF ADMINISTRATION (mixed with food, spoon, etc.)	DOSAGE	DATE	TIME	COMMENTS	SIGNATURE/INITIALS OF PERSON ADMINISTERING/OBSERVING ADMINISTRATION

(To be placed in The Documentation File of O.S.R.)

SS-02-56(a) (INT)

MEDICATION	DESCRIPTION OF MEDICATION (pill, liquid, colour, etc.)	METHOD OF ADMINISTRATION (mixed with food, spoon, etc.)	DOSAGE	DATE	TIME	COMMENTS	SIGNATURE/INITIALS OF PERSON ADMINISTERING/OBSERVING ADMINISTRATION

(To be placed in The Documentation File of O.S.R.)



MEDICATION INVENTORY RECORD

SCHOOL _____

SCHOOL YEAR _____

STUDENT'S NAME	MEDICATION	DATE RECEIVED	QUANTITY	RECEIVED BY	DATE & QUANTITY RETURNED TO PARENT /GUARDIAN	RETURNED TO (SIGNATURE OF PARENT /GUARDIAN)

(To be placed in Principal's Central File)
SS-02-56(b) (INT)

STUDENT'S NAME	MEDICATION	DATE RECEIVED	QUANTITY	RECEIVED BY	DATE & QUANTITY RETURNED TO PARENT /GUARDIAN	RETURNED TO (SIGNATURE OF PARENT /GUARDIAN)

(To be placed in Principal's Central File).

F-20.



ADULT STUDENT/PARENTS/GUARDIANS
EPILEPSY RESPONSIBILITIES CHECKLIST

- Inform the school of the student's epilepsy.
- Meet with the school administration and appropriate school staff, e.g. Classroom Teacher, prior to the student's first day of school and provide information related to the student's epileptic condition including:
 - special needs or concerns regarding the health and care of the student;
 - typical signs and treatment of the epilepsy;
 - when the school is to contact us, e.g. after each incident of a seizure, etc.;
 - review school management guidelines concerning causes, prevention, identification and treatment of epilepsy and include highlighted special signs or characteristics for the student.
- Complete the following forms and submit them to the School Principal before the student's first day of school:
 - Request and Consent for Epilepsy Interventions form;
 - Individual Epilepsy Action Plan.
- Inform school administration regarding changes in the student's health, lifestyle, epilepsy procedures, management and emergency contact numbers on an on-going basis.
- Teach the student:
 - the importance of wearing an epilepsy identification (e.g. Medic Alert™) at all times;
 - age appropriate understanding of the causes, identification, prevention and treatment of epilepsy;
 - to recognize the first symptoms of epilepsy;
 - to communicate clearly to adults/those in authority that he or she has epilepsy and when feeling a reaction starting or a general sensation of not feeling well;
 - to take as much responsibility as possible for his or her own safety.

Appendix H

HAMILTON-WENTWORTH CATHOLIC DISTRICT SCHOOL BOARD

STUDENT WITH EPILEPSY
RESPONSIBILITIES CHECKLIST

- Wear my Medic Alert™ identification at all times during the school day.
- Have age appropriate understanding of my epilepsy.
- Recognize symptoms of a seizure.
- Promptly inform an adult that I have epilepsy as soon as symptoms appear or when experiencing a general sensation of not feeling well.

SUPPORTING

Ontario Children and Students with Medical Conditions

QUICK FACTS



Supporting children and students with epilepsy in Ontario

Promoting child and student well-being is one of the four key goals in “Achieving Excellence: A Renewed Vision for Education in Ontario.” Ensuring the health and safety of children and students with medical conditions requires a partnership among families, members of the school community and community partners, including health care professionals.

Epilepsy overview

Epilepsy results from sudden bursts of hyperactivity in the brain; this causes “seizures” which vary in form, strength, and frequency, depending on where in the brain abnormal activity is found. **Epilepsy is the diagnosis and seizures are the symptom.** If a person has two or more seizures that are not related to another condition, that person will be diagnosed as having epilepsy.

Epilepsy facts

- Each year 15,500 Canadians are diagnosed as having epilepsy.
- Epilepsy affects over 300,000 Canadians and approximately 1 in 100 Canadian students.
- Seizures can range from a prolonged stare in which the student is fully aware, to a loss of awareness, physical convulsions, or the student’s whole body becoming stiff. While surgery is sometimes an option, the most common way of managing epilepsy is single or multiple drug therapies.

Living with epilepsy

When managed effectively an individual with epilepsy can pursue a regular and productive life. Often times, the social anxiety and stigma around epilepsy is more detrimental to an individual’s quality of life than the physical symptoms of the condition. Some triggers for epilepsy include alcohol, unmanaged stress and environmental conditions (e.g., flashing lights). When avoiding these triggers, an individual should not be prevented from participating fully in any form of activity. With effective management and accommodation, living with epilepsy should not be a barrier to success.

Creating an inclusive environment at school

All children with epilepsy — no matter how independent they are — need the support of trusted, caring adults at school and elsewhere.



Making children aware of different medical conditions is essential to creating an inclusive environment. Once a child is diagnosed with epilepsy, parents should explain to the child in simple language what the condition is and why it happens. Encouraging children and students to speak to their friends about their condition will help them to find support and understanding amongst their peers.

Ongoing communication between the school, the student and the family is essential when a student is diagnosed with epilepsy and is starting school. Maintaining an open exchange of information is also important throughout the school year, especially if there are changes to the student's medical condition.

Families should work with the school to create an individualized Plan of Care for their child. The plan will include support strategies or ways to accommodate student's so they can participate to their full potential in school activities.

The Ministry of Education expects all district school boards and school authorities in Ontario to develop and maintain policies to support students with asthma, anaphylaxis, diabetes, and epilepsy in schools.

Emergencies

In the case of an emergency related to epilepsy, school staff should refer to the child's individualized Plan of Care. When an epileptic event is happening, it is important to stay calm and support the individual having the seizure. It is not essential to call 9-1-1 when someone is having a seizure; however, if the seizure lasts more than 5 minutes, or repeats without full recovery, seek medical assistance immediately. If you witness a student having a seizure, do not restrain the child, but try to move sharp and cornered objects away in order to prevent injury, and let the seizure run its course.

In all emergency situations:

1. Stay calm.
2. Dial 9-1-1.
3. Inform the student's emergency contact, as outlined in their Plan of Care.

Where to find more information

Epilepsy Ontario:

<http://epilepsyontario.org/>

Healthy Schools, Ministry of Education:

<http://www.edu.gov.on.ca/eng/healthyschools/medicalconditions.html>



Hamilton-Wentworth Catholic District School Board
Believing, Achieving, Serving

CONSENT TO THE DISCLOSURE, SHARING AND EXCHANGE OF VERBAL INFORMATION, TRANSMITTAL OR EXAMINATION OF A RECORD

I (We) _____
(PRINT FULL NAME)

of _____
(ADDRESS)

Hereby consent to the disclosure, sharing and exchange of verbal information or transmittal to, or examination by:

(Name of Person, Agency, or Institution)

of _____
(Identify Material: Clinical record, Report, File, Verbal Disclosure, etc.)

compiled/prepared by: _____
(Name or Names as Appropriate)

in respect of _____
(Name of Student and School)

for the purpose of _____

Nature of the information to be released _____

_____.

(Signature)

(Witness)*

(If other than Student, state relationship to Student)

Dated the _____ day of _____, 20____.

This Consent is valid for the remainder of the school year, from the date of signature, that is,
The _____ day of _____, 20____. Unless previously withdrawn in writing.

*** In the absence of other convenient witnesses, the professional may serve as witness.**

HAMILTON-WENTWORTH CATHOLIC DISTRICT SCHOOL BOARD

9-1-1- Protocol Epilepsy
TO BE POSTED BY TELEPHONE IN MAIN OFFICE

1. This is _____ School.
2. We are located at:
Address: _____
Nearest Major Intersection: _____
Telephone Number: _____
3. We have a student who is experiencing symptoms of an Epileptic Seizure.
We need an ambulance immediately
4. The closest entrance for the ambulance is on: _____
Ave./Road/Street
5. A staff member will be outside of the school entrance to provide more information.
6. Do you need any more information?
7. How long will it take you to get here?
8. Call parent/guardian/emergency contact.



Policy Manual - Students - Miscellaneous

S.M.19 Epilepsy

To accomplish these objectives, the Hamilton-Wentworth Catholic District School Board shall make every reasonable effort to:

- ensure that school board personnel are aware of which students within the school population have been diagnosed with Epilepsy; and,
- outline the procedures necessary to manage Epilepsy as well as to intervene effectively in the event of an epileptic emergency.

Responsibility: Superintendents of Education, Assistant Superintendent of Education and Special Education Programs and Services

Regulations:

- Education Act, 1990
 - o Section 264 - Duties of Teacher
 - o Section 265 - Duties of Principal
- Regulation 298 - Operation of Schools – General
 - o Section 11 - Duties of Principals
 - o Section 20 - Duties of Teachers
- Regulation Made Under the Teaching Profession Act - Section 14(f)
- Good Samaritan Act, 2001
- Ministry of Education Policy/Program Memorandum No. 161 - Supporting Children and Students with Prevalent Medical Conditions (Anaphylaxis, Asthma, Diabetes and/or Epilepsy) in Schools, September 2018

Related Policies: S.M. 11 Allergic Reaction (Anaphylaxis Awareness); S.M.12 Asthma; S.M.18 Diabetes

Related Board Committee: Committee of the Whole

Policy Review Date: BM Original Policy Approved 19 June 18

Revisions: To be reviewed every three (3) years