SUDBURY CATHOLIC
DISTRICT SCHOOL BOARD

Medical Conditions Package for Epilepsy

PARENTS/GUARDIANS

SUDBURY CATHOLIC DISTRICT SCHOOL BOARD

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Introduction:
This Epilepsy and Seizure Disorder Protocol addresses the components of Ministry of Education Policy/Program Memorandum #161 Supporting Children and Students with Prevalent Medical Conditions (Epilepsy/Seizure Disorder) in Schools.

Responsibilities of Parents/Guardians with School:
In order for School Staff to provide a safe and nuturing environment for students managing their Epilepsy Parents/Guardians are asked to:

- **Provide Proof of Diagnosis for your child which can be ONE of**:
    - A letter/note from the physician or specialist, OR
    - A copy/photocopy of the prescription, OR
    - A photocoy of the prescription from the medicine container, OR
    - A copy/photcopy of the Offical Receipt of the medication from the pharmacist
- **COMPLETE and return the following forms found in this package:**
    - **STUDENT PLAN OF CARE**
        - Parents/Guardians of newly registered or newly diagnosed students shall create the Student Plan of Care in consultation with School Adminstration during September or as soon as possible to starting the school year. For students already registered, **the Student Plan of Care should be reviewed and/or updated annually and shared with the school, before the start of each school year.**
    - **CONSENT FORM TO CARRY AND ADMINISTER MEDICATION/DISCLOSE PERSONAL INFORMATION**
        - Form is completed by Parent/Guardian to carry and self-administer medication. Also includes consent to share life-threatening condition with pertinent individuals.

Please Note – Urgency of Having Completed Forms as Soon as Possible:
To act in the best interest of your child responding to a seizure, you are strongly encouraged to provide all relevant information and forms to manage your child's Epilepsy to the school principal in a timely manner. Failure to do so may place your child at unnecessary risk.

- **Provide Information about:**
    - Types of seizures
    - Triggers for your child's seizure e.g. strobe lights
    - Warning signs e.g. 'auras' or other indicators that a seizure might occur
    - Recommend procedures to follow during seizure and first aid required
    - Determine when parent/guardian emergency contact is to be made
    - Determine when 911 ambulance is to be called
    - Medications taken by the student, if/when taken at school and any side effects
    - If your child experiences incontinence and/or enuresis during a seizure, provide your child's classroom with a pillow, blanket and a change of clothes
    - Post seizure symptoms or behaviours

- **UPDATE Changes of information: Emergency Contact, Medication, Medical Diagnosis**:

Parents are responsible to inform School Adminstration of any changes to contact information, medication or medical condition diagnosis as soon as reasonably possible. Forms can be accessed through the school office.

NOTE: Changes to your child's diagnosis must be accompanied by a note/letter from your chlid's physician indicating the change.

Please Note: Board employees are not trained health professionals

- **COMMUNICATE, when your child is transitioning to a new school, with the new school in June.**
  You should ask for a most recent copy of your child's Epilepsy/Seizure Disroder Student Plan of Care. You are requested to update the form with recent medical and contact information and to provide the completed form to the receiving school administrator/designate during a transition meeting.

Responsibilities of Parent/Guardian with your Child:

- Provide age appropriate information on the causes, identification, prevention and treatment of seizures
- Inform your child of the importance of carrying medical information about his/her medical condition and their medications as directed by the child's health care professional.
- Supply your child and/or school with sufficient quantities of medication in an original, clearly labelled container, tracking the expiration dates.
- Guide and encourage your child to self-management and self-advocacy.
- Inform your child that when they are having a seizure, never remove themselves to a secluded area or go off to be by themselves (e.g. washroom) and to tell a teacher, staff member or a classmate when feeling a reaction or when feeling unwell.
- Encourage your child to reach their full potential for self-management and self-advocacy.
- Consider providing a Medical Alert identification for your child (e.g. bracelet or necklace). The form can be obtained by calling 1-800-668-1507 or visit www.medicalalert.ca

Responsibilities of Students

- Where appropriate know the causes, symptoms, how to minimize or prevent and the treatment for their epilepsy/seizure disorder
- Advocate for their personal safety and well-being
- Participate in the development and review of their Plan of Care
- Carry out daily or routine self-management of their medical conditions as described in their Plan of Care
- Set goals on an ongoing basis for self-management of their medical condition in conjunction with their parents and healthcare professional
- When feeling unwell or experiencing symptoms of a seizure to not remove themselves to a secluded area or go off by themselves (e.g. washroom). Tell a teacher or classmate that you are experiencing difficulty and need help
- Wear medical alert identification that they and/or their parents/guardians deem appropriate

- If possible, inform school staff and/or peers if a medical incident or emergency occurs
- Communicate with parents/school staff if they are facing challenges related to their Epilepsy/Seizure Disorder, including any, and all, teasing, bullying, threats or any other concerns they have

School Forms

- **STUDENT PLAN OF CARE: EPILEPSY IDENTIFICATION AND EMERGENCY TREATMENT PLAN**
    - To identify your child to others, this form will be created from information included in the Student Plan of Care, by the School Adminstrator, and will be shared with appropriate school staff and posted in your child's classroom. This form will also be provided to the Sudbury Student Services Transportation Consortium.
    - If the Child's requires an EPI Pen then this form must also be filled out http://www.businfo.ca/en/pdf/forms/F-M04-401%20English%20EpiPen%20Form%20Consortium.pdf
    - The Consortium's Medical Information Form must also be filled in by a medical professional http://www.businfo.ca/en/pdf/forms/F-M04-404%20-%20Medical%20Note.pdf
- **AT-A-GLANCE Medical Disorder IDENTIFICATION**

To identify your child to others, an At-A-Glance document is created, by the School Adminstrator/Designate, which includes the student's name, grade, picture, and medical condition only and is only posted in pertinent staff areas (i.e. staff room).

- **CONSENT FORM TO CARRY AND ADMINISTER MEDICATION/DISCLOSE PERSONAL INFORMATION**
    - Form is completed by Parent/Guardian to carry and self-administer medication. Also includes consent to share life-threatening condition with pertinent individuals.

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PREVALENT MEDICAL CONDITION — EPILEPSY - PLAN OF CARE

STUDENT INFORMATION

Student Name _____ Date of Birth _____

Ontario Ed. # _____ Age _____

Grade _____ Teacher(s)/Courses _____

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

☐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? _____

_____

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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: _____

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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

✸Always notify parent(s)/guardian(s) or emergency contact.

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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. See Plan Renewal

PLAN

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

PLAN REVIEW

Where there is no change in the child's condition or treatment strategy from the previous year(s), parents may authorize continuation of the protocol with initials below.

☐ There has been no change in condition or treatment strategy from previous year. Parent initial: _____
Date: _____

☐ There has been no change in condition or treatment strategy from previous year. Parent initial: _____
Date: _____

☐ There has been no change in condition or treatment strategy from previous year. Parent initial: _____
Date: _____

SUDBURY CATHOLIC DISTRICT SCHOOL BOARD

CONSENT FORM
TO CARRY AND ADMINISTER MEDICATION/DISCLOSE PERSONAL INFORMATION

TO BE SIGNED BY PARENT/GUARDIAN UNLESS THE STUDENT IS 18 YEARS OF AGE OR OLDER

ADMINISTRATION OF MEDICATION

In the event of my child _____ experiencing a medical emergency, I consent to the administration of _____ (specify type of medication) by an employee of the Sudbury Catholic District School Board as prescribed by the physician and outlined in the Emergency Procedures of the Prevalent Medical Conditions Policy/Administrative Procedure.

PLEASE PRINT Student's Name: _____ Name of Parent/Guardian: _____ Signature of Parent/Guardian: _____ Signature of Student (if 18 or older): _____	Class/Teachers' Names: Date: _____ Date: _____

MAINTENANCE OF MEDICATION

I understand that it is the responsibility of my child _____to carry _____ (specify type of medication) on his/her person.

PLEASE PRINT Student's Name: _____ Name of Parent/Guardian: _____ Signature of Parent/Guardian: _____ Signature of Student (if 18 or older): _____ Name of Physician: _____	Class/Teachers' Names: Date: _____ Date: _____ Contact # _____

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COLLECTION, DISCLOSURE AND USE OF PERSONAL INFORMATION

Authorization for the collection and maintenance of the personal information recorded on the Prevalent Medical Conditions form is the Municipal Freedom of Information and the Protection of Privacy Act. Users of this information should be directed by the principal of the school.

OPTIONAL:

Additionally, I further consent to the disclosure and use of the personal information collected herein to persons, including persons who are not the employees of the Sudbury Catholic District School Board through the posting of photographs and medical information of my child (Plan of Care/Emergency Procedures) in the following key locations:

☐ Classroom	☐ Staffroom	☐ Lunchroom
☐ Office	☐ Gym	☐ Learning Commons/Library
☐ Other: _____	☐ Other: _____	

and through the provision of personal information contained herein to the following persons who are not employees of the Board: please check (✓) all applicable boxes

☐ Food Service Providers	☐ Child Care Providers
☐ School Volunteers in regular direct contact with child	☐ Other: _____

Signature of Parent/Guardian: _____	Date: _____
Signature of Student (if 18 or older): _____	Date: _____
Signature of Principal: _____	Date: _____

We release the Sudbury Catholic District School Board, its employees and agents from any and all liability for loss, damage or injury, howsoever caused to my/our child's person, or property, or to me/us as a consequence, arising from administering the interventions, failing to correctly administer the interventions and/or failing to administer any intervention listed in Epilepsy/Seizure Disorder Student Plan of Care.

Signature of Parent/Guardian: _____	Date: _____
Signature of Student (if 18 or older): _____	Date: _____

PLEASE NOTE THIS CONSENT EXPIRES AT THE END OF THE CURRENT SCHOOL YEAR

This information is collected pursuant to s. 170 and s.265(1)i) of the Education Act, R.S.O. 1990, c. E-2 and s.28(2), 29, 30, 31,32 and 33 of the Municipal Freedom of Information and Protection of Privacy act, R.S.O. 1990, c. M-56: and the Personal Health Information Protection Act, 2004, S.O. 2004, c.3, Sch. A.
If you have any questions regarding your child's personal information, please contact the Principal of your child's school.

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AT-A-GLANCE Medical Condition IDENTIFICATION

Student Name	Grade	Medical Condition	Picture (If avaialble)