Nora Frances Henderson Secondary School

PROUD SCHOOL OF HAMILTON-WENTWORTH DISTRICT SCHOOL BOARD

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September 18, 2019

Dear Parents and Guardians,

To promote the safety and well-being of students with prevalent medical conditions-Epilepsy, parents/or guardians are encouraged to confirm annually to the Principal or Principal's designate the student's medical status by completing and submitting appropriate forms. As such, **attached you will find:**

- Epilepsy Plan of Care (Appendix D)
- Daily Routine Epilepsy Management
- Healthcare Provider Information (Optional)
- Authorization/Plan Review, Consent Form to Carry and Administer Medication/Disclose Personal Information (Appendix G3)

Please complete the attached forms and return to the Main Office as soon as possible, but no later than Wednesday, September 30th. A picture of your child will be attached to the Epilepsy Plan of Care and shared with the appropriate staff.

If you have any questions, please contact Vice-Principal Jason Monteith via phone or by email at jsmontei@hwdsb.on.ca.

Sincerely,

Jason Monteith
Vice Principal
Nora Frances Henderson Secondary School

HWDSB

Appendix E

EPILEPSY
Plan of Care

STUDENT INFORMATION

Student Name _____ Date Of Birth _____

OEN # _____ Age _____ Student Photo (optional)

Grade _____ Teacher(s) _____

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? _____

Post copy of page one in staff only area

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.

HEALTHCARE PROVIDER INFORMATION (OPTIONAL)

Healthcare provider may include: Physician or Nurse Practitioner

Healthcare Provider's Name: _____

Profession/Role: _____

Signature: _____ Date: _____

Special Instructions/Notes/Prescription Labels:

If medication is prescribed, please complete the Authorization of Administration of Oral Prescription Medication (Appendix F).

*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).

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

Student: _____ Date: _____
Signature

Principal: _____ Date: _____
Signature

Information on this form is collected under the legal authority of the Education Act and in accordance with Sections 28 and 29 of the Municipal Freedom of Information and Protection of Privacy Act, R.S.O. 1990 (MFIPPA). The purpose of the form is to support children with prevalent medical conditions and foster healthy and safe environments in which students can learn. We take your privacy seriously and have policies in place to make sure your information is protected (see our Privacy and Information Management Policy 1.6). Questions or concerns should be directed to your school principal.

File in student Prevalent Medical Conditions folder with Plan of Care. Also file a copy in the OSR. Retain until superseded or no longer in effect.