SCHOOL DISTRICT No. 36 (Surrey)

MEDICAL ALERT INFORMATION AND CARE PLAN (Epilepsy)

Student Name: _____

Birthdate: _____ Personal Health Number: _____

Date Information Provided: _____

Date when this information was reviewed by Parent/Guardian (minimum annually):

_____ (date of review)	_____ (date of review)	_____ (date of review)
_____ (date of review)	_____ (date of review)	_____ (date of review)

School emergency contact information:

	Name	**Phone Number**
Family Doctor		
Mother		
Father		
Alternate Contact		
Alternate Contact		
Alternate Contact		

Medical Condition (Physician diagnosed): _____

_____

Specific Symptoms to watch for:

1. _____
2. _____
3. _____
4. _____
5. _____

Procedures to deal with a problem: – EPILEPSY **–**

When a person with epilepsy has a seizure …

1. Keep calm.
2. **DO NOT** restrain their movements. Loosen tight fitting clothing.
3. **Ensure that the student is not in any danger from sharp objects.**
4. After jerking of seizure has subsided, and if student is still unconscious, turn them on their side with their face gently turned downward.
5. **DO NOT** put anything between their teeth.
6. **DO NOT give them anything to drink.**
7. Stand by until the student has fully recovered consciousness from the confusion which sometimes follows a seizure.
8. Notify parent or guardian. Regular seizures are not normal.
9. Let them rest if they feel tired, then encourage them to go about their regular activities.

Additional Comments: _____

_____

Medication needed: YES □ NO □ Location at the School: _____

Medication is Self Administered: YES □ NO □

Name of Medication: _____ Expiry Date: _____

Details (Specific side effects, storage, etc):

_____

_____

_____

Training Documentation:

Name of School	Date of Training/Review	Trainer

- I am aware of Board Policy and Regulation on the Treatment of Students with Medical Problems.
- I agree that the above information is correct.
- If changes occur I will contact the school and provide revised instructions.
- I agree that if medication is required I will supply it to the school in the original container with my child's name and the pharmacist's directions for use, including dosage.
- I am aware that no medication will be administered until this form is completed and returned.
- I am aware that the Public Health Nurse for the school will be informed of my child's condition and medication and that the nurse may contact me as necessary.
- I am aware that staff working with my child may need to know of my child's condition and of the medication required.
- I am aware I am required to update this information each September.

_____ _____

(Date) (Signature of Parent/Guardian)