Surrey Schools
LEADERSHIP IN LEARNING

Form # 25900.40
Safe Schools

MEDICAL ALERT INFO & CARE PLAN
(EPILEPSY/SEIZURE)

To be completed when the school agrees with the parental request to administer medication. To be reviewed at least annually. A new form must be completed if medication changes. This form is to be filed at the school.

A. TO BE COMPLETED BY THE PARENT

Student Name *(Last Name, First Name)*	D.O.B. *(dd/month/year)*	Gender ❑ M ❑ F	Student #
Address	City/ Province	Postal Code	Personal Health Card #

Student Home Phone #	MedicAlert® I.D. ❑ Yes ❑ No	Teacher	Grade	Div	Classroom #

Name of Father	Home Phone #	Other #
Name of Mother	Home Phone #	Other #
Name of Guardian	Home Phone #	Other #

Emergency Contact Person	Relationship to Student	**Phone #**
Alternate Contact Person	Relationship to Student	Phone #

B. SEIZURE INFORMATION

Diagnosed with Seizures (year):	**Last Seizure:** **Frequency:**

Describe your child's seizures *(type of seizure, symptoms, warning signs, triggers)*:

Special considerations *(regarding school activities, sports, trips, physical education etc.)*:

C. MEDICATIONS: *TO BE COMPLETED BY THE ATTENDING PHYSICIAN / FAMILY DOCTOR*

For medication which MUST be taken during school hours or during school sponsored events
(Instructions re: storage of medication for refrigeration, etc.)

Name of Medication:	***Expiry Date:***
Reason for Medication	
Method of Administration (Dosage, time of administration)	Self-Administered ❑ Yes ❑ No
Additional Instructions	
What is the impact of a missed dose?	

Name of Physician (please print)	*Signature of Physician*	*Date*	Phone #

MEDICAL ALERT INFO & CARE PLAN
(EPILEPSY/SEIZURE)

D. MEDICAL INTERVENTIONS

When a person with epilepsy has a CONVULSIVE SEIZURE:

STAY WITH THE CHILD

- Protect from injury:
  - Remove any sharp or solid objects from nearby
  - Cushion the child's head
- Loosen anything tight around neck
- Do not restrain the child
- Do not put anything in the child's mouth
- Gently roll child on side
- Stay with the child until they ar ere-oriented
- Record Time
- School staff will document seizure on 'Seizure Activity Record' form if required.
- Other interventions required (e.g., emergency medication): ____________
  ____

Call parents when: ____

Call 911 when: ____

When a person with epilepsy has a NON-CONVULSIVE SEIZURE:

STAY WITH THE CHILD

- Remove any dangerous object from nearby
- Do not attempt to move child until reoriented
- Don't try to stop the child from wandering unless the child is in danger
- Don't shake the child or shout
- Record Time
- School staff will document seizure on 'Seizure Activity Record' form if required.
- Other interventions required (e.g., emergency medication): ____________
  ____

Call parents when: ____

Call 911 when:
____

D. TO BE COMPLETED BY THE PARENT / GUARDIAN

Initials

__________ 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, or as it changes.

I authorize and request the administration of the above medication from ________________________to ________________________.

I will provide the medication in the original container with expiration date, labelled by a pharmacist.

____ ________________________

Signature of Parent / Guardian *Date*

E. TO BE COMPLETED BY THE PRINCIPAL OR DESIGNATE

Staff designated to supervise/administer medication

Alternate(s)

Location of Medication in the School

______________________________ ______________________________ ______________________

Name of Principal or Designate (please print) *Signature of Principal or Designate* *Date*

F. TRAINING DOCUMENTATION

Date of Training / Review	Name of Trainer