

## 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. **NOTE: This is NOT a delegated Nursing Support**Services (NSS) Care Plan. A child is eligible for Nursing Support Services if they experience frequent seizures and they require interventions, during a seizure, over and above basic seizure first aid which includes one or more of the following: administration of emergency medication, use of a Vagal Nerve Stimulator, oxygen administration, suctioning.

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ddress			City/ Province	Postal Code Personal Health Ca		lealth Card #	
ident Home Phone #	MedicAlert® I.D.	Teacher		Grade	Div	Classroom #	
	☐ Yes ☐ No						
ne of Father			Home Phone #		Other#		
lame of Mother			Home Phone #	e Phone #		Other#	
lame of Guardian			Home Phone #		Other#	Other#	
mergency Contact Person			Relationship to Student Phone #				
ernate Contact Person			Relationship to Student	Phone #			
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agnosca With Ocizaros (year).			Frequency:				
ecial considerations (regard	ding school activities, s	sports, trips, p.	hysical education etc.):				
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## **MEDICAL ALERT INFO & CARE PLAN**

(EPILEPSY/SEIZURE)

## **MEDICAL INTERVENTIONS** When a person with epilepsy has a CONVULSIVE SEIZURE: When a person with epilepsy has a NON-CONVULSIVE SEIZURE: STAY WITH THE CHILD STAY WITH THE CHILD Protect from injury: Remove any dangerous object from nearby Do not attempt to move child until reoriented Remove any sharp or solid objects from nearby Don't try to stop the child from wandering unless the child is in danger Cushion the child's head Loosen anything tight around neck Don't shake the child or shout Do not restrain the child Record Time Do not put anything in the child's mouth School staff will document seizure on 'Seizure Activity Record' form if Gently roll child on side Stay with the child until they are re-oriented Other interventions required (e.g., emergency medication): 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 parents when: Call 911 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