Seizure care plan

for education, child/care and community support services*

CONFIDENTIAL

To be completed by the DOCTOR and the PARENT/GUARDIAN and/or ADULT STUDENT/CLIENT.
This information is confidential and will be available only to supervising staff and emergency medical personnel.

Name of child/student/client _____ Date of birth _____
Family name (please print) First name (please print)

MedicAlert Number (if relevant) _____ Date for review _____

Description of this person's usual seizure activity

Warning signs *(eg sensations)*

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Known triggers *(eg illness, elevated temperature, flashing lights)*

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Seizure Types	Further information about this person's seizures
Tick all those that apply.	Please indicate typical seizure frequency and length, and any management that is a variation from standard seizure management.
☐ **Tonic clonic**	**Tonic clonic**
☐ Not responsive ☐ Might fall down/cry out ☐ Body becomes stiff (tonic) ☐ Jerking of arms and legs occurs (clonic) ☐ Excessive saliva ☐ May be red or blue in the face ☐ May lose control of bladder and/or bowel ☐ Tongue may be bitten ☐ Lasts 1-3 minutes, stops suddenly or gradually ☐ Confusion and deep sleep (maybe hours) when in recovery phase. May have a headache.	
☐ **Absence**	**Absence**
☐ Vacant stare or eyes may blink/roll up ☐ Lasts 5-10 seconds ☐ Impaired awareness (may be seated) ☐ Instant recovery, no memory of the event.	
☐ **Simple partial**	**Simple partial**
☐ Staring, may blink rapidly ☐ Only part of the brain is involved (partial) ☐ Person remains conscious (simple), able to hear, may or may not be able to speak ☐ Jerking of parts of the body may occur ☐ Rapid recovery ☐ Person may experience sensations that aren't real: ▪ sounds ▪ flashing lights ▪ strange taste or smell ▪ 'funny tummy' ▪ or may just have a headache These are sometimes called an aura and may lead to other types of seizures.	

Seizure Types	Further information about this person's seizures
Tick all those that apply.	Please indicate typical seizure frequency and length, and any management that is a variation from standard seizure management.
☐ **Complex partial**	**Complex partial**
☐ Only part of the brain is involved (partial) ☐ Person staring and unaware. Eyes may jerk but may talk, remain sitting or walk around ☐ Toward the end of the seizure, person may perform unusual activities, eg chewing movement, fiddling with clothes (these are called automatisms) ☐ Confused and drowsy after seizure settles, may sleep.	
☐ **Myoclonic**	**Myoclonic**
☐ Sudden simple jerk ☐ May recur many times.	

Recovery management

Signs that the seizure is starting to settle

Duration *(How long does recovery take if the seizure isn't long enough to require midazolam?)*

Person's reaction

Any other recommendations to support the person during and after a seizure

Additional information attached to this care plan

- ☐ Medication authority
- ☐ Seizure management flow chart
- ☐ Observation/seizure log for completion by staff *(please specify how frequently this is requested)*

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- ☐ General information about this person's condition
- ☐ Other *(please specify)*

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***This plan has been developed for the following services/settings:**

- ☐ School/education
- ☐ Child/care
- ☐ Respite/accommodation
- ☐ Transport
- ☐ Outings/camps/holidays/aquatics
- ☐ Work
- ☐ Home
- ☐ Other *(please specify)*

AUTHORISATION AND RELEASE

Medical practitioner/epilepsy specialist _____ Professional role _____

Address _____

_____ Telephone _____

Signature _____ Date _____

I have read, understood and agreed with this plan and any attachments indicated above.
I approve the release of this information to supervising staff and emergency medical personnel.

Parent/guardian
or adult student/client _____ Signature _____ Date _____
Family name (please print) First name (please print)