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**Seizures: Know Me, Support Me**



Place Image Here

 **Seizure Management Plan**

|  |
| --- |
| Name of person living with seizures:  |
| Date of birth:  | Date plan Written:  | Date to review:  |

**1. General Information**

|  |  |
| --- | --- |
| Medical Information Located:  |  |
| Seizure Management Plan Located:  |  |
| Medical Conditions:  |  |
| Medications: |   |

**2. Has emergency seizure medication been prescribed? Yes**[ ]  **No** [ ] If yes, the medication authority or emergency management plan must be attached and followed, if you are specifically trained

|  |  |  |
| --- | --- | --- |
|  | Emergency Medication Management Plan Location:  |  |
|  | Current Weight:  |  |

**3. My seizures are triggered by:**

For example, heat, light, being unwell, fatigue

|  |
| --- |
|    |

**4. Changes in my behaviour that may indicate a seizure could occur:**

For example, pacing, sad, irritability, poor appetite, usually very mobile but now sitting quietly

|  |
| --- |
|  |

**5. My seizure description and seizure support needs:**

Complete a separate row for each type of seizure – use, brief concise language to describe each seizure type

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Description of seizure** Make sure you describe what the person looks like before, during and after and if they typically occur in a cluster | **Typical duration of seizure** seconds/minutes | **Usual frequency of seizure** in terms of seizures per month, per year, or per day | **Is emergency medication prescribed for this type of seizure?** | **When to call an ambulance** If you are trained in emergency medication administration refer to the EMMP and the medication authority |
|  |  |  | Yes [ ] No [ ]  | If you are untrained in emergency medication call ambulance when:  |

**6. How I want to be supported during a seizure:**

Specify the support needed during each of the different seizure types

If you are ever in doubt about my health during or after the seizure, call an ambulance

|  |  |  |
| --- | --- | --- |
|  | **Seizure Type** | **Support Needed** |
|  |  |
|  |  |
|  |  |  |

**7. My specific post-seizure support:**

State how a support person would know when I have regained my usual awareness and how long it typically takes for me to fully recover.

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Seizure Type** | **Post- Seizure Behaviour** | **Support Needed** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**8. My risk/safety alerts:**

For example, bathing swimming, use of helmet, mobility following seizure. 

|  |  |
| --- | --- |
| **Risk** | **What will reduce risk for me** |
|  |  |
|  |  |
|  |  |
|  |  |

**9. Do I need additional support? Yes** [ ]  **No** [ ]

If yes describe. For example wheelchair, supervision with stairs, non-verbal

|  |
| --- |
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**This plan has been co-ordinated by:**

|  |  |
| --- | --- |
| Name:  | Organisation:  |
| Telephone numbers:  |  |
| Association with person: For example treating doctor, parent, case manager |  |

|  |  |
| --- | --- |
| Individual’s Signature: Parent/Guardian if under 18 | Date:  |

**Primary contact:**

|  |  |
| --- | --- |
| Name:  | Relationship:  |
| Telephone:  |

**Endorsement by treating doctor:** 

|  |
| --- |
| Your doctor’s name:  |
| Telephone:  |
|  |  |
| Doctor’s Signature: | Date |