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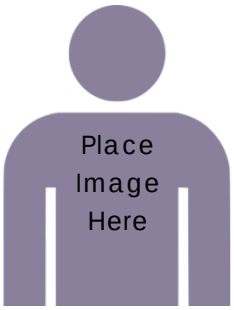
Seizures: Know Me, Support Me

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

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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

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