



Epilepsy  
Action  
Australia  
life changing impact



# SEIZURE MANAGEMENT PLAN

DATE :

***This person experiences seizures. This plan provides important information that helps manage their seizures and step by step instructions for assisting during a seizure.***

Person with Epilepsy: Personal Details		
Name		
Date of Birth		
Address		
Email		
Phone		
Emergency Contacts		
Relationship	Name	Phone
Medical History		
<b>Medical History</b> <i>(other conditions such as asthma)</i>		
<b>Seizure History</b>		
<b>Known Allergies</b>		
<b>Medication name(s)</b>		
<b>Emergency Medication</b> (if prescribed) <b>See emergency medication order attached</b>	<b>Medication name:</b> <b>Route:</b> (intranasal, buccal) <b>Seizure type to administer:</b>	

Name:

Date:

Seizure Type 1	
<b>Type</b> (if known)	<b>Description:</b>  <b>How long does it last?</b> <b>How frequently do they occur?</b>
<b>Triggers &amp; Management</b> e.g. Overtiredness – avoid overexertion and keep routine sleep patterns	
<b>Warning signs of seizure</b> e.g. mood change	
<b>What to do</b> (first aid)	
<b>When to call an ambulance</b>	
<b>Recovery</b> (what to do after seizure)	

Name:

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Special Considerations	
<b>Safety Considerations</b>	
<b>Supervision Needs</b> eg transport, excursions	
<b>Other Instructions</b>	
Endorsement by Treating Doctor	
<b>Doctor's Name</b>	
<b>Telephone</b>	
<b>Doctor's Signature</b>	
<b>Date</b>	
<b>Date for plan review</b>	

 [Seizure First Aid Poster](#)

 [Administration of Emergency Medications for Seizures Order Form](#)

Name:

Date: