



**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		
Medical History <i>(other conditions such as asthma)</i>		
Seizure History		
Known Allergies		
Medication name(s)		
Emergency Medication (if prescribed) See emergency medication order attached	Medication name: Route: (intranasal, buccal) Seizure type to administer:	

Name:

Date:

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

Name:

Date:

Seizure Type 2	
Type (if known)	Description: How long does it last? How frequently do they occur?
Triggers & Management e.g. Overtiredness – avoid overexertion and keep routine sleep patterns	
Warning signs of seizure e.g. mood change	
What to do (first aid)	
When to call an ambulance	
Recovery (what to do after seizure)	

Name:

Date:

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

 [Seizure First Aid Poster](#)

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

Name:

Date: