

# 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.
<input type="checkbox"/> <b>Tonic clonic</b>	<b>Tonic clonic</b>
<input type="checkbox"/> Not responsive <input type="checkbox"/> Might fall down/cry out <input type="checkbox"/> Body becomes stiff (tonic) <input type="checkbox"/> Jerking of arms and legs occurs (clonic) <input type="checkbox"/> Excessive saliva <input type="checkbox"/> May be red or blue in the face <input type="checkbox"/> May lose control of bladder and/or bowel <input type="checkbox"/> Tongue may be bitten <input type="checkbox"/> Lasts 1-3 minutes, stops suddenly or gradually <input type="checkbox"/> Confusion and deep sleep (maybe hours) when in recovery phase. May have a headache.	
<input type="checkbox"/> <b>Absence</b>	<b>Absence</b>
<input type="checkbox"/> Vacant stare or eyes may blink/roll up <input type="checkbox"/> Lasts 5-10 seconds <input type="checkbox"/> Impaired awareness (may be seated) <input type="checkbox"/> Instant recovery, no memory of the event.	
<input type="checkbox"/> <b>Simple partial</b>	<b>Simple partial</b>
<input type="checkbox"/> Staring, may blink rapidly <input type="checkbox"/> Only part of the brain is involved (partial) <input type="checkbox"/> Person remains conscious (simple), able to hear, may or may not be able to speak <input type="checkbox"/> Jerking of parts of the body may occur <input type="checkbox"/> Rapid recovery <input type="checkbox"/> Person may experience sensations that aren't real: <ul style="list-style-type: none"><li>▪ sounds</li><li>▪ flashing lights</li><li>▪ strange taste or smell</li><li>▪ 'funny tummy'</li><li>▪ or may just have a headache</li></ul>	
These are sometimes called an aura and may lead to other types of seizures.	

## Seizure care plan (cont)

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

## Recovery management

### Signs that the seizure is starting to settle

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

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### Person's reaction

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

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### 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:

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|------------------------------------------------|----------------------------------------------------------|
| <input type="checkbox"/> School/education      | <input type="checkbox"/> Outings/camps/holidays/aquatics |
| <input type="checkbox"/> Child/care            | <input type="checkbox"/> Work                            |
| <input type="checkbox"/> Respite/accommodation | <input type="checkbox"/> Home                            |
| <input type="checkbox"/> Transport             | <input type="checkbox"/> Other ( <i>please specify</i> ) |

#### 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)