

# 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>  <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>Tonic clonic</b>
<input type="checkbox"/> <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>Absence</b>
<input type="checkbox"/> <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.	<input type="checkbox"/> <b>Simple partial</b>

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>
<p><input type="checkbox"/> <b>Complex partial</b></p> <p><input type="checkbox"/> Only part of the brain is involved (partial)</p> <p><input type="checkbox"/> Person staring and unaware. Eyes may jerk but may talk, remain sitting or walk around</p> <p><input type="checkbox"/> Toward the end of the seizure, person may perform unusual activities, eg chewing movement, fiddling with clothes (these are called automatisms)</p> <p><input type="checkbox"/> Confused and drowsy after seizure settles, may sleep.</p>	<p><b>Complex partial</b></p>
<p><input type="checkbox"/> <b>Myoclonic</b></p> <p><input type="checkbox"/> Sudden simple jerk</p> <p><input type="checkbox"/> May recur many times.</p>	<p><b>Myoclonic</b></p>

**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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