Seizure Care Plan

Student's Name: ______________________________ **Grade:**________ **Div:** ______
Facility Name: ____________________ **Facility Address:**______________________________

Student's Full Name:

Date of Birth:

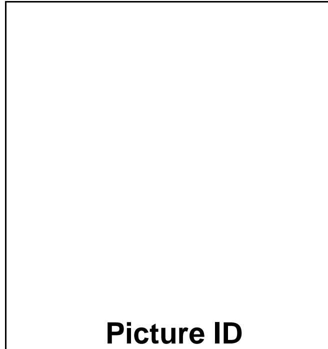
Parent/Guardian:

Phone (home/cell): Phone (work):

Emergency Contact:

Phone (home): Phone (work):

Health Care Provider: Phone:



Picture ID

HISTORY:

Type of Seizure:

Date of last seizure: How often do they occur:

☐ Student wears a Medic-Alert

Is the student taking medication ☐ Yes ☐ No

If Yes name of medication: Dose:

How long have they been taking this medication:

Additional Information about medication:

USUAL SEIZURE PRESENTATION:

What happens during a seizure:

Warning signs before a seizure:

CARE PLAN INFORMATION:

☐ Names of staff oriented to plan:

☐ Emergency plan review date (to do yearly):

Websites: www.bcepilepsy.com www.epilepsy.ca

EMERGENCY TREATMENT FOR SEIZURES:

- Keep Calm.
- Do not restrain student during the seizure
- Protect student from injury:
  - Move hazardous objects out of the way
  - Lower student to the floor
  - Protect head
  - Do not put anything in the students mouth
- When seizure has subsided, turn onto side gently to keep airway clear.
- Stay with student and provide reassurance and privacy
- **Call 911 if seizure lasts more than 5 minutes, or if student has several seizures in a row.**
- Notify parent/guardian

It is the parent's responsibility to notify the facility of any change in the child's condition.

Sign below if you agree with above Information & Plan:

Health Care Provider (eg. Dr/Specialist/NP)	Date
Parent/Guardian	Date
Childcare Supervisor/School Personnel	Date

Seizure Care Plan is provided as a resource from Vancouver Coastal April 2013

Vancouver Coastal Health
Promoting wellness. Ensuring care.