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| **First Aid Seizure Management Plan** | | | | | | | | | | | |
| Child/Adolescent: | |  | | | | Date of Birth: | |  | | | |
| Parent/Guardian: | |  | | | | Contact Number(s): | |  | | | |
| Treating Clinician: | |  | | | | Contact Number(s): | |  | | | |
| **Seizure Type 1** | | | | | | | | | | | |
| **Seizure Type** | | **Duration** | **Frequency** | | **Description of the seizure – including triggers and warning signs** | | | | | | |
|  | |  |  | |  | | | | | | |
| **Specific First Aid Management:** | |  | | | | | | | | | |
| **Emergency medication order?** | | | | Yes (refer to attached administration sheet) | | | | | | No | |
| **Seizure Type 2** | | | | | | | | | | | |
| **Seizure Type** | | **Duration** | **Frequency** | | **Description of the seizure – including triggers and warning signs** | | | | | | |
|  | |  |  | |  | | | | | | |
| **Specific First Aid Management:** | |  | | | | | | | | | |
| **Emergency medication order?** | | | | Yes (refer to attached administration sheet) | | | | | | No | |
| **General First Aid Principles** | | | | | | | | | | | |
| * **Stay with the child and try to time the seizure** * **Move hard objects away and protect head from injury** * **Place on the side (recovery position) to keep airway clear** * **Provide comfort and reassurance after the seizure and allow to rest and sleep** * **If confused or unusual behavior, gently guide away from harm and ensure safety** * **DO NOT place anything in the mouth** | | | | | | | | | | | |
| **IF SEIZURE ACTIVITY CONTINUES OR THERE ARE MULTIPLE SHORT SEIZURES  FOR GREATER THAN 5 MINUTES, CALL FOR AN AMBULANCE – DIAL 000** | | | | | | | | | | | |
| Name of Prescribing  Doctor: |  | | | | Signature: | |  | | Date: | |  |
| Name of Parent: |  | | | | Signature: | |  | | Date: | |  |