Epilepsy and Seizure Management Plan

Child's Name:		**Date:**	
Epilepsy and Seizures Management			
What type of seizures affect your child?			
How often does your child have seizures?	☐ Infrequently (<5 times/year) ☐ Frequently (5+ times/year) ☐ Most days/daily ☐ When triggered		
When did the child's last seizure occur?			
Approximately how long did the episode last for?			
How do you recognize that your child is having a seizure?			
1.			
2.			
Other signs:			
How do you recognize that your child has recovered from a seizure?			
What are your child's seizure triggers (known and possible triggers)?			
Does your child understand the condition?	☐ Yes ☐ No		
Does your child know when they are having a seizure?	☐ Yes ☐ No		
Does your child require medication whilst at the centre?	☐ Yes ☐ No		
Medication	**Dose**	**Time given**	**Administration (i.e. tablet)**
Additional comments:			
Parent/Guardian Name: **Signature:** **Date:**		**Centre Director Name:** **Signature:** **Date:**	