

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?		<input type="checkbox"/> Infrequently (<5 times/year)	<input type="checkbox"/> Frequently (5+ times/year)		
		<input type="checkbox"/> Most days/daily	<input type="checkbox"/> 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?		<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Does your child know when they are having a seizure?		<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Does your child require medication whilst at the centre?		<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Medication	Dose	Time given	Administration (i.e. tablet)		
Additional comments:					
Parent/Guardian Name:			Centre Director Name:		
Signature:			Signature:		
Date:			Date:		

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RECORD MANAGEMENT SCHEDULE	Child Enrolment - C+3yrs				
Ensure you are using the latest version of this policy. You can find it at http://policies.goodstart.org.au/PoliciesandProcedures/NQS2%20Epilepsy%20and%20Seizures%20Management%20Plan%20APPEN DIX.docx					
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