## Epilepsy and Seizure Management Plan

<table>
<thead>
<tr>
<th>Child’s Name:</th>
<th>Date:</th>
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</thead>
</table>

### Epilepsy and Seizures Management

**What type of seizures affect your child?**

- □ Infrequently (<5 times/year)
- □ Frequently (5+ times/year)
- □ Most days/daily
- □ When triggered

**How often does your child have seizures?**

<table>
<thead>
<tr>
<th>How often</th>
<th>Infrequently (&lt;5 times/year)</th>
<th>Frequently (5+ times/year)</th>
<th>Most days/daily</th>
<th>When triggered</th>
</tr>
</thead>
</table>

**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

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dose</th>
<th>Time given</th>
<th>Administration (i.e. tablet)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

**Additional comments:**

**Parent/Guardian Name:**

**Signature:**

**Date:**

**Centre Director Name:**

**Signature:**

**Date:**