Seizure Emergency Action Plan for ____________ year

Child's Name: ______________________________________ **Age:** ________

Centre Name: _________________________ **Centre Address:** ____

Child's Full Name:

Date of Birth:

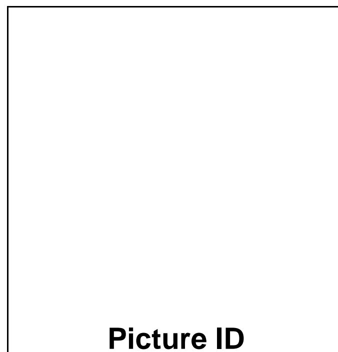
Parent/Guardian:

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:

☐ Child wears a Medic-Alert

Is the child 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:

Name/s of staff oriented to the plan:______________________________

Emergency Plan review date: (to be reviewed yearly) ____________________

EMERGENCY TREATMENT FOR SEIZURES:

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

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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:

_______________________ _____________

Parent/Guardian Date

_______________________ _____________

Child Care Staff: Date