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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**
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| **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: |  |