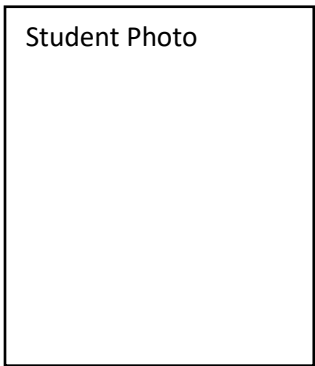


# SEIZURE DISORDER MANAGEMENT PLAN

(Note: This form (or copy) must be taken on all out of school activities/field trips)



Student: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Teacher: \_\_\_\_\_

## EMERGENCY CONTACT: List order to call 1-2-3:

Mother's Name \_\_\_\_\_ Contact Number \_\_\_\_\_

Father's Name \_\_\_\_\_ Contact Number \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Contact Number \_\_\_\_\_

**Health/Diagnostic Information:** include information about type of medication, dosage and frequency; note the possibility of incontinence during loss of consciousness. Ensure a blanket and pillow are available and where appropriate a change of clothes.

**MEDICAL DIAGNOSIS:** \_\_\_\_\_

**Triggers Preceding a Seizure** (if known):

**Frequency of Seizure Activity** (if known):

**Description of Seizure (Non-Convulsive):**

**Required Action:**

**Description of Seizure (Convulsive):**

**Required Action:**

**FIRST AID TREATMENT –TONIC CLONIC:**

Procedure will be to call 911 immediately unless there is written instructions from child’s physician to do otherwise.

There are written instructions \_\_\_\_\_yes \_\_\_\_\_no.

If yes - attach physician’s instructions to this form.

**Medication:**

(Prior to medications being administered by school staff the Board’s ‘Request and Consent for Administration of Prescribed Medication’ Form must be completed by parent/guardian and provided to school administrator).

**Name of Medication:**

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**Specific direction to administer medication (time, with or without food/drink etc):  
(Note: Rectal suppositories will not be administered by Board staff.)**

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**Possible Side effects:**

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**OTHER INFORMATION:**

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I/We will immediately contact the School if I believe that circumstances might require an amendment to amend the Management Plan outlined above>

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date