Updated March 2012

Saved as Epilepsy Management Plan

PALMWOODS KIDS CLUB EPILEPSY MANAGEMENT PLAN

Child's Name:	Sex: M F	Date of Birth:/
(First Name)	(Family Name)	
Epilepsy Diagnosis:		
PERSONAL DETAILS	_	
Parent's Name:		
Telephone: (H)	(W)	M)
Emergency Contact (e.g. pare	nt/carer):	
Relationship:		
Emergency Contact Telephon	e: (H) (W)	
	(M)	
Doctor:	Telephone:	
CURRENT EPILEPSY MED	ICATION	
	case of emergency a supply must be	provided and kept on the premises.
Name of Medication	Method of Administration	Dose Regime (eg.8am—200mg)
SEIZURE DESCRIPTION		•
Name the type of seizure, if k the seizure. Remember to incl	<u> </u>	e what happens before, during and after ild has more than one type of seizure. zures.

SEIZURE TRIGGERS			
THER SEIZURE TREATM	ENTS		
urgery 🗆	Ketogenic Diet	Vaga Nerve Stimulator (VNS) 🛚	
Please list below any specific	instructions/relevant information		
OTHER CURRENT MEDICA	ATION		
	case of emergency a supply must be p	provided and kept on the premises.	
Name of Medication	Method of Administration	Dose Regime (eg.8am—200mg)	
	EPILEPSY FIRST AID	PLAN	
Please describe below the <u>Sei</u>	<u>zure First Aid Procedure</u> specific to yo	our child:	
Whan would you like Kids Cl	ub staff to call an Ambulance if your c	ahild avnavianaas a sairuva?	
vnen would you like Klas Cl	uo siajj to can an Amounance ij your c	chila experiences a seizure:	
VI	11 1	9	
v nat is requirea for your chi	ld during the post-seizure monitoring?	(
• Please notify me if my	child has had a seizure and received Fi	irst Aid	
• In the event of an seizu	ire, I agree to my son/daughter receivin	ng the treatment described above.	
	e are any changes to these instructions. uses incurred for any medical treatment		
	ises incurred for any medical treatment	•	
	e:		