

EPILEPSY Management Plan

Date of Doctor's Instructions: _____ Today's Date: _____

Person's Name: _____ Gender: _____ Date of Birth: _____

EMERGENCY CONTACT PERSON(S)

1. Name: _____ Phone Home: _____ Mobile/Work: _____

2. Name: _____ Phone Home: _____ Mobile /Work: _____

3. Name: _____ Phone Home: _____ Mobile/Work: _____

Treating Doctor: _____ Phone: _____

EPILEPSY DIAGNOSIS & DETAILS

Type of seizure/s: _____

Known triggers: _____

Seizure pattern: (What happens before, during and after) _____

EPILEPSY MEDICATIONS

	Name	Dose	Time Given	Form of Administration
eg.	<i>Epilim</i>	<i>200mg</i>	<i>8am</i>	<i>tablet</i>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

In the event of a seizure, I _____ authorize the management / staff / carers to follow the emergency action plan for _____ as presented on the back of this document.

Signed: _____

Date: _____

EPILEPSY Action Plan

The Emergency Action Plan should include step by step instructions to help management / staff / carers manage this particular individual's seizures. It should also indicate the specific circumstance in which an ambulance should be called.

EMERGENCY ACTION PLAN

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Epilepsy Australia recommends regular consultation with the treating doctor to assist with details for this emergency action plan. Information must be current and changes need to be communicated to carers.

Date of last seizure	Types of seizure/s	Did an ambulance attend?
New Form Required		