



Southern Oregon Child & Family Council, Inc.

Seizure Plan

Child's Name: _____ Date of Birth: _____

Parent(s) or Guardian(s) Name(s): _____

Emergency Contact Phone # (during class hours):

Mother: _____ Father: _____ Other: _____

Primary Health Care Provider: _____ Phone #: _____

Has the child's seizure condition been diagnosed by a physician? YES NO Date diagnosed: _____

If YES, type of Seizure (tonic-clonic, partial complex, absence): _____

How often does the child have seizures? _____ Date of Last Seizure: _____

When is the child most likely to have a seizure? _____

Does the child take any seizure medication? YES NO

If YES, list medications: _____

Are seizures being controlled by the above medication? YES NO

Are seizures typically associated with fever? YES NO

If YES, please explain: _____

Has the child ever been hospitalized for seizures? YES NO

If YES, please explain: _____

Typical signs and symptoms of the child's seizure episodes (Check all that apply):

- | | | |
|---|---|--|
| <input type="checkbox"/> Staring | <input type="checkbox"/> Jerking movement of arms/legs | <input type="checkbox"/> Stiffening of the body |
| <input type="checkbox"/> Loss of Consciousness | <input type="checkbox"/> Breathing problems | <input type="checkbox"/> Loss of bowel/bladder control |
| <input type="checkbox"/> Falling suddenly | <input type="checkbox"/> No response to words for brief periods | <input type="checkbox"/> Appears confused or in a haze |
| <input type="checkbox"/> Sleeplessness | <input type="checkbox"/> Irritability upon waking | <input type="checkbox"/> Head nodding |
| <input type="checkbox"/> Periods of rapid eye blinking or staring | | |

Other (specify): _____

Describe how the child acts after a seizure? _____

What does the parent do to comfort the child after a seizure? _____

STEPS CENTER STAFF SHOULD TAKE WHEN SEIZURES ARE OBSERVED:

1. Maintain a calm presence and offer continuous verbal reassurance to the child
2. Protect child from injury from surrounding objects
3. Prevent injury by placing a pillow or soft object under the child's head
4. If seizure is severe, help child maintain a clear airway by laying child on his/her side
5. DO NOT RESTRAIN CHILD OR PUT ANYTHING INTO CHILD'S MOUTH
6. After seizure reassure and slowly refocus child to surroundings
7. Contact parent and document in doc log
8. Refer to Healthcare Provider information on page 2 of Seizure Plan