Epilepsy Care Plan

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| --- | --- | --- | --- |
| Name (Student)AddressTelephone |  | | |
| EmergencyContact x1 |  | | |
| EmergencyContact x2 |  | | |
| **Seizure Information**  Type/What to look for/length | What Happens | How long | How often |
|  |  |  |
|  |  |  |
| **Triggers** |  | | |
| **Emergency Medication** How much/how to give |  | | |
| **Daily Seizure Medicine** | We need to know this so this information can be passed to ambulance services. | | |
| What should the PA/Driver do for your child?Ring for an ambulance/give emergency medication |  | | |
| Any other information you would like us to share with the contractors |  | | |
|  |  | | |

This form will be shared with Transport providers who work with your child.