NSW GOVERNMENT Health

Facility:

PAEDIATRIC FIRST AID SEIZURE MANAGEMENT PLAN FOR PARENTS/CARERS/SCHOOL

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. _____ / _____ / _____	M.O.
ADDRESS	
LOCATION / WARD	

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

First Aid Seizure Management Plan

Child/Adolescent:		Date of Birth:	
Parent/Guardian:		Contact Number(s):	
Treating Clinician:		Contact Number(s):	

Seizure Type 1

Seizure Type	Duration	Frequency	Description of the seizure – including triggers and warning signs

Specific First Aid Management:		
Emergency medication plan?	☐ Yes (refer to attached administration sheet)	☐ No

Seizure Type 2

Seizure Type	Duration	Frequency	Description of the seizure – including triggers and warning signs

Specific First Aid Management:		
Emergency medication plan?	☐ Yes (refer to attached administration sheet)	☐ No

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SMR060.030

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Seizure Type 3

Seizure Type	Duration	Frequency	Description of the seizure – including triggers and warning signs

Specific First Aid Management:	

Emergency medication plan?	☐ Yes (refer to attached administration sheet)	☐ No

General Seizure First Aid Principles

- **Stay with the child and try to time the seizure**
- **Move hard objects away and protect head from injury**
- **Place on the side (recovery position) to keep airway clear**
- **Provide comfort and reassurance after the seizure and allow to rest and sleep**
- **If confused or unusual behaviour, gently guide away from harm and ensure safety**
- **DO NOT place anything in the mouth**
- **If seizure activity continues or there are multiple short seizures for greater than 5 minutes, call for an ambulance (dial 000), unless instructed otherwise by the treating clinician**

This form should be regularly reviewed with your treating Clinician.

Name of Treating Clinician:	Signature:	Date:
Name of Parent/Guardian:	Signature:	Date:

Further information: Paediatric Epilepsy Network NSW (www.pennsw.org.au) or Epilepsy Action Australia (https://www.epilepsy.org.au/)

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