ACT Government
Education and Training

Epilepsy Management and Emergency Treatment Plan

For schools and preschools

This record is to be completed by parents/carers in consultation with their child's doctor (general practitioner). Parents/carers should inform the school immediately if there are any changes to the plan. Please print your answers clearly in the blank spaces where indicated.

The Directorate collects the information contained in this form to provide or arrange first aid and other medical treatments for students. The information collected will be held at your child's school and will be made available to staff of the school and to medical or paramedical staff in the case of an accident or emergency. The information contained in the form is personal information and it will be stored, used and disclosed in accordance with the requirements of the *Privacy Act 1998(Cwth)*. Parents/carers note that in the absence of an Emergency Treatment Plan only standard First Aid should be administered.

Personal Details

Student's name:……..

Sex: M ☐ F ☐ Date of birth:……..Year/Class……

Emergency contact (e.g. parent, carer):

a.Name:……Relationship:……..
Telephone No:……(Hm)……(Wk/Mobile)

b.Name:……Relationship:……
Telephone No:……(Hm)……(Wk/Mobile)

Doctor:……Telephone No……

Insert student's photo here

Medical Information

Epilepsy diagnosis (if known):……
……...
……..

Seizure pattern (What happens before, during and after the seizure):
……
……
……
Seizure normally lasts for……minutes

Epilepsy triggers (if known):……..……..
……
……

Epilepsy medication

Name	Dose	Time/s	How given
……..	……	……	……..
……..	……	……	……..

In an **Emergency** follow the Plan below that has been ticked (✓).

☐ Epilepsy Emergency Treatment Plan

1. Call ambulance if:……
2.Transport:……..
3. Student should be sent home when:……
4. Swimming:……
5. Diarise seizures (yes/no):……..

OR

☐ My Child's Emergency Treatment Plan (attached)

I verify that I have read the Epilepsy Emergency Treatment Plan and agree with its implementation.

Signature of Doctor: …… Date:……Date of Plan:……

Signature of Parent/Carer:…… Date:……

a) I/We (Parent/Carer)……give permission for my/our child (Name) ……

1. to be treated by staff at school, in an emergency, using the preferred Epilepsy Emergency Treatment Plan.

2. to be identified by a Student Medical Alert poster including a photograph of my child and personal information which is to be displayed in the school's first aid and medical treatment room/s, staff room/s and other locations as considered necessary. These locations will be discussed with the parents/carers prior to action.

b) As a parent/carer I will notify you in writing if there are any changes to these instructions.

Signed……Dated……