YMCA of
Hamilton/Burlington/Brantford

INDIVIDUAL SEIZURE ACTION PLAN

Child's Name: ______________________ **Date of Birth:** ______________________

Centre: ______________________ **Date Individualized Plan Completed:** ______________________

MEDICAL INFORMATION

Does your child have Epilepsy? (please check) ☐ Yes ☐ No

Please check what type of seizure your child experiences (check all that apply):

☐ Absent Seizures (Petit Mal) ☐ Tonic - Clonic (Grand Mal) ☐ Simple Partial ☐ Febrile
☐ Complex Partial ☐ Other ______________________

Date of last seizure: ______________________ **Average time of day:** ______________________

Average frequency (how often): ______________________ **Average length of seizure:** ______________________

PREVENTION AND SUPPORTS

List possible triggers or steps the YMCA should take to reduce the risk of causing or escalating the seizure:

Behaviour/Body signs and symptoms during the seizure that the YMCA should monitor (check all that apply):

☐ Sudden fall ☐ Brief staring spell ☐ Walks around ☐ Repetitive or aimless activities
☐ Loss of bladder ☐ Confusion ☐ Headache ☐ Stomach ache
☐ Fatigue ☐ Aura (warning) ☐ Other (please list) ______________________

Does your child require any medication or medical devices: ☐ Yes ☐ No

If yes, list the medication/describe the device, use and location: ______________________

ACTION PLAN AND EMERGENCY PROCEDURES

When Educators see the above signs and symptoms, they should respond by:

**Please note that if seizures occur frequently a tracking sheet with most recent seizure will be attached*

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Procedures to follow during an evacuation: (e.g. ice packs for medication, items that require refrigeration, how to assist the child to evacuate, **or not applicable (N/A)**)
Procedures to follow during Field Trips: (e.g.. how to plan for offsite excursions, how to assist and care for the child during a field trip, **or not applicable (N/A)**)

WHEN TO SEEK MEDICAL ATTENTION

If it is determined that immediate medical attention is required:

1. **Call 911.** Tell them that someone is having a seizure, the length of time and provide them with background information.
2. **Call Parents/Emergency Contacts.**
3. **Go to the nearest hospital.** Educator must accompany child to the hospital.
4. **The child's Individual Seizure Action Plan and Child Registration Form should accompany the child to the hospital and shared with medical personnel.**

EMERGENCY CONTACT INFORMATION

Name	Relationships	Home Phone	Work Phone	Cell Phone

PARENT/GUARDIAN CONSENT

☐ This plan has been created in consultation with the child's parent/guardian.

Parent/Guardian Name ____________ Parent/Guardian Signature ____________ Date: ____________

**If a child experiences a seizure in program an Accident/Incident Report will be completed and the parents/guardian will be contacted. When in a School Age Child Care or Preschool Child Care program, educators will also track this information on the daily record and record of accident/illness tracking.*
**Please note if child is registered in more than one YMCA program for the school year, this information must be reviewed by the parent or guardian to ensure it is current and accurate.*

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The policies and procedures listed below will be reviewed prior to employment and at least annually.

All educator, students, and volunteers will review the individual plan for each child before they begin employment/ participation/placement and at least annually thereafter. As well, all educator, students and volunteers will review the Individual Seizure Action Plan of any new children prior to them starting the program.

*I have read and understand the Individual Seizure Action Plan for the following child located at:

Centre: ______________________________ Child's Name: ______________________________

Educator Signature	Print Educator's Name	Reviewing Supervisor's Initials	Date
Educator Signature	Print Educator's Name	Reviewing Supervisor's Initials	Date
Educator Signature	Print Educator's Name	Reviewing Supervisor's Initials	Date
Educator Signature	Print Educator's Name	Reviewing Supervisor's Initials	Date
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**attach to the back side of the Individual Seizure Action Plan*

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