



## 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  
 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:



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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)

**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)

### 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.*



## INDIVIDUAL SEIZURE ACTION PLAN

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
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*\*attach to the back side of the Individual Seizure Action Plan*