SEIZURE PLAN OF CARE

Name: ____ DOB: ______________________

Type of seizures: ____

Seizure History: ____

Usual seizure frequency: ____

Describe typical seizure: ____

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Length of typical seizure: ____

Plan of Care (Responsibilities for the plan of care will be assigned in the CSSP and reviewed annually by the team.)

1. Anticonvulsant medications administered and blood levels drawn as ordered by the physician.
2. All seizures will be documented. The following will be noted: date, time, length of seizure, specific body movements and behaviors exhibited during the seizure, and post-ictal state.
3. First aid for seizures will be administered, an incident report will be completed for injury or if 911 is called.

Seizure Precautions

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Seizure Protocol

PRN Medication ordered? ☐ No ☐ Yes – Medication ___________________________________

Dose ______________________ Route ________________________ See attached orders/instructions

Vagal Nerve Stimulator (VNS) ordered? ☐ No ☐ Yes See attached orders/instructions

When to call 911

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Who to notify

☐ Group home/Day program ☐ Legal representative ☐ Physician ☐ Nurse ☐ Other ________

Original source of information: _________________________________ Date ___________________

___________________________________ ______________________

Nurse Signature Date

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