

EPILEPSY INFORMATION FORM



Date: _____

Client's name: _____ Age: _____

Clients phone number: _____

Emergency contact person: _____ Phone: _____

Doctor: _____ Phone: _____

Epilepsy Diagnosis (if known): _____

Seizure Pattern (what happens before during and after the seizure): _____

Epilepsy triggers: _____

Epilepsy Medication

Name	Dose	Time/s	How (route) given

Other Medication

Name	Dose	Time/s	How (route) given

EPILEPSY MANAGEMENT ACTION PLAN

I hereby authorise the staff/carers to follow this Epilepsy Management Plan.

Signed: _____ Parent / Legal guardian _____ Doctor