

Phone: 519.433.4073 Toll Free: 1.866.EPILEPSY 797 York St., Unit 3 London ON, N5W 6A8

www.epilepsyswo.ca Charitable registration number: 11890 0802 RR0001



Seizure Information

Name: Birth Date: Diagnoses:			
	Phone:		
act:	Relation:		
ontact:	Relation:		
tion			
Description	When it's a medical emergency		
lasts more than 5 minutes or repects diabetes, is injured from the seizu Move sharp objects out of the way. If their head. If the person wanders about 15 minutes are selected in the person wanders about 15 minutes are selected.	its without full recovery between seizures, call 911. Call 911 if the		
	Diagnoses:		



My Seizure Plan

YOUR	Name: Birth Date:			Date:		
PHOTO HERE	Diagnosis:					
Allergies:						
->-						
C) Rescue Medico	ation					
My child requires res		ıtion: □ Yes □ No				
If no, please skip to	section D.					
Type of Medicat	tion Dosage		Method	Who to Administer		
This plan is validate	d by treating	y physician				
 Signature			Date			
signature						
D) Health Care Co	ontacts					
Epilepsy Specialist:			Phoi	Phone:		
Preferred Hospital:			Physician: _	Physician:		
E) Special instruc	tions:					
Parent signature				Date		
Community Agency Educator Signature				Date		