



Last Updated _____

Care Plan for: _____ **Nickname:** _____

Primary Care Provider: _____ Phone: _____ Fax: _____
Address: _____ email: _____

Neurology Care Provider _____ Phone: _____ Fax: _____

Primary Language: _____

DOB: _____ Sex: M F

Caregiver1 Name: _____

Address: _____ City/State/Zip: _____

Contact Info: _____
(home #) (work #) (cell #) (email address)

Caregiver2 Name: _____

Address: _____ City/State/Zip: _____

Contact Info: _____
(home #) (work #) (cell #) (email address)

Emergency Contact Name(s): _____

Relationship: _____ Phone: _____

Insurance: _____ Phone: _____

Do you have any transportation needs?

(Please explain): _____

SEIZURE INFORMATION

Date of Last Seizure: _____

Date of First Seizure: _____

Date of Diagnosis: _____

Seizure Type/Nickname	What Happens	How Long it Lasts	How Often

TRIGGERS

Pharmacy: _____ Phone: _____ Address: _____

Allergies: _____

Care Plan for _____

Medications	Dose, How Taken (time of each dose and how much)	Ordered by/date	D/C date

Device Type: _____ Model: _____ Serial # _____ Date Implanted: _____

Dietary Therapy: _____ Date Begun: _____

Special Instructions: _____

Other Therapy: _____

WHEN SEIZURES REQUIRE ADDITIONAL HELP

Type of Emergency (long, clusters or repeated events)	Description	What to Do

"AS NEEDED" TREATMENTS (VNS magnet, medicines)

Name	Amount to Give	When to Give	How to Give

SEIZURE FIRST AID

- Keep calm, provide reassurance, remove bystanders
- Keep airway clear, turn on side if possible, nothing in mouth
- Keep safe, remove objects, do not restrain
- Time, observe, record what happens
- Stay with person until recovered from seizure
- Other care needed: _____

CALL 911 OR SEEK EMERGENCY MEDICAL ATTENTION IF...

- Generalized seizure longer than 5 minutes
- Two or more seizures without recovering between seizures
- "As needed" treatments don't work
- Injury occurs or is suspected, or seizure occurs in water
- Breathing, heart rate or behavior doesn't return to normal
- Unexplained fever or pain, hours or few days after a seizure
- Other care needed: _____

Challenges (Check ALL that apply and explain on the line below):

- | | | | |
|---|-------------------------------------|--|---|
| <input type="checkbox"/> Behavior | <input type="checkbox"/> Learning | <input type="checkbox"/> Stamina/Fatigue | <input type="checkbox"/> Communication |
| <input type="checkbox"/> Respiratory | <input type="checkbox"/> Orthopedic | <input type="checkbox"/> Mental Health | <input type="checkbox"/> Hearing/Vision |
| <input type="checkbox"/> Physical Anomalies | <input type="checkbox"/> Sensory | <input type="checkbox"/> Other: _____ | |

Explain: _____

EPILEPSY FOUNDATION OF FLORIDA CASE MANAGER: _____ PHONE: _____



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Care Plan for _____

Therapists (PT/OT/ST/DT)	Phone/Fax numbers	Frequency of Services

School Services: Special Education 4560 Form IEP Name of School _____

School Nurse (name/phone): _____

School Teachers/Therapists: _____

Social worker, Counselor/Dean: _____

Other Service Agencies (Early Intervention, Home Health Care, Care Coordinators, Respite, etc.): _____

Dentist: _____

Comments on child, family, or other specific medical issues: _____

Does family need help with resources? No Yes, Explain: _____

Does family need respite care? No Yes, Explain: _____

Community Resources (Check ALL that apply and explain on the line below):

Caseworker: _____ (name/phone/fax)

Caseworker: _____ (name/phone/fax)

Caseworker: _____ (name/phone/fax)

SSI Waiver Program TBI DDMR

WIC Work Force Service Food Stamps Child Care

Permissions

I give my permission to share the information in this care plan with all of my child's providers and those listed in this plan.

EXCEPT: _____

I give permission for the staff of Epilepsy Foundation of Florida to share my information with other community contacts (Parent Groups, Community resources, etc.) to help provide better care for my child/ren.

Parent/Legal Guardian Signature: _____ Date: ____ / ____ / ____

Date plan sent to providers: _____ by: _____

Physician Signature/Date: _____

Completed by: _____



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