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Attach this document to your Epilepsy/Seizure Management Plan. This Emergency Plan should be completed and signed by the prescribing doctor in consultation with the person and/or their family or carer. It is recommended that this plan be reviewed and signed by the person's doctor annually.

Emergency Medication Management Plan

Name of Drug (Name)

(only to be administered by a trained person)

Name:

Date of birth: Weight:

1. FIRST DOSE Name of Drug (Name)

First dose = drops ml mg **(drops should be given by spoon)**

For single seizures:

As soon as a *(seizure type)* begins

If the *(seizure type)* continues longer than mins

Special instructions:

For clusters of seizures:

When *(number)* *(seizure type)* occurs within mins hrs

Other *(please specify)*:

Special instructions:

2. SECOND DOSE Name of Drug (Name)

First dose = drops ml mg **(drops should be given by spoon)**

Not prescribed

OR

If the *(seizure type)* continues for another mins following the first dose

When another *(number)* *(seizure type)* occurs within mins hrs following the first dose

Other *(please specify)*:

Special instructions:

3. Maximum number of Name of Drug (Name) doses to be given in a 24-hour period

Maximum number:

Client Name DOB:

4. Dial 000 to call the ambulance:

Prior to administering Name of Drug (Name)

If the seizure has not stopped   minutes after giving the Name of Drug (Name)

Other (please specify):

5. Describe what to do after Name of Drug (Name) has been administered:

6. Prescribing doctor or specialist

Doctor's name:	Telephone:

Signature: Date:

7. Storage and family special instructions

Recommended Name of Drug (Name) storage information:

- **Keep out of reach of children**
- **Store at room temperature (below 25°C)**
- **Regularly check the expiry date.**

Any special instructions e.g. storage of medication, when on outings etc.
or people to contact if emergency medication is given.

Emergency contact name:	
Relationship:	Telephone:

Signature: Date:

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Client Name DOB: