



Heart of Illinois Special Recreation Association
8727 North Pioneer Road, Peoria, IL 61615
P: 309-691-1929, F: 309-691-4383
hisra@peoriaparks.org

Form #2: Seizure Care Plan

Participant Name: _____

This care plan outlines all information necessary to support a participant who may experience seizures along with an emergency plan if/when a seizure may occur.

Seizure Type (please check all that apply)

Generalized Seizures (Produced by the entire brain):

- “Grand Mal” or Generalized Tonic-Clonic:** Participant loses consciousness and usually collapses. The loss of consciousness is followed by generalized body stiffening for 30 to 60 seconds, then violent jerking for 30 to 60 seconds, after which the participant normally goes into a deep sleep.
- Absence Seizures:** This type of seizure causes a short loss of consciousness (just a few seconds) with few to no symptoms. The participant typically interrupts an activity and stares blankly.
- Myoclonic Seizures:** This consists of the participant experiencing sporadic jerks, usually on both sides of the body. Jerks can be described as brief electrical shocks. When violent, these seizures may result in dropping or involuntarily throwing objects.
- Clonic Seizures:** Symptoms are normally repetitive, rhythmic jerks that involve both sides of the body at the same time.
- Tonic Seizures:** Characterized by stiffening of the muscles
- Atonic Seizures:** These seizures consist of a sudden and general loss of muscle tone, particularly in the arms and legs, which often results in a fall.

Partial Seizures (Produced by a small area of the brain):

- Simple:** (including simple motor, simple sensory and simple psychological) Symptoms include jerking, muscle rigidity, spasms, head-turning, unusual sensations affecting either the vision, hearing, smell, taste or touch and memory or emotional disturbances. Awareness is retained during a simple seizure.
- Complex:** Participant may experience automatisms such as lip smacking, chewing, fidgeting, walking and other repetitive, involuntary but coordinated movements.
- Partial Seizure with Secondary Generalization:** Characterized by symptoms that are initially associated with a preservation of consciousness that then evolves into a loss of consciousness and convulsions.

A cooperative extension of the Chillicothe, Morton, Peoria and Washington Park Districts providing quality recreation programs and services to individuals with disabilities.



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Seizure Characteristics

What does a typical seizure look like?

What part of body is typically affected? _____

Typical duration of seizure (mins): _____

How often does participant experience seizure activity? _____

When was participant's last known seizure? _____

Check any factors that may cause a seizure:

Blinking lights (video games, TV, etc.)

Participant is very tired or overexerted

Other (please explain on lines below):

Participant has recently been sick

High/hot environmental temperature

Participant has just awoken

Check any behaviors or symptoms participant may exhibit **before** a seizure:

Participant feels ill

Participant has elevated body temperature

Other (please explain on the lines below):

Participant feels tired

Confusion

Blank staring

Steps to Take in the Event of a Seizure

Please check the following you would like to be implemented in the event that the participant experiences a seizure:

Call 911 immediately

***Disclaimer: 911 WILL be called if participant experiences a seizure that continues for 5 minutes or longer.**

Call parent or legal guardian

Give *as needed* medication or device to emergency personnel upon arrival.

***Disclaimer: HISRA employees are not able to administer any medication or devices that require medical judgment (e.g. vagal nerve stimulators, diazepam rectal gel, etc.)**

Other: _____



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Steps to take Following a Seizure

Please check the following that should be implemented **following** a seizure:

- Allow to rest/sleep
- Take to restroom
- Do not give anything to eat or drink for _____ minutes.
- Additional instructions: _____
- _____
- _____

Seizure Treatment

Please Circle Yes or No:

Has the participant been treated in the emergency room due to their seizures? **Yes or No**

If **yes**, how many times? _____

When was the most recent time? _____

Has the participant stayed overnight in the hospital due to their seizures? **Yes or No**

If **yes**, how many times? _____

When was the most recent time? _____

Are seizures controlled by medication? **Yes or No**

If **yes**, please fill out the chart below.

Seizure Medication Chart

***DISCLAIMER: HISRA employees are not able to administer any medication or use any devices that require medical judgment (vagal nerve stimulator, diazepam rectal gel, etc.) Please see Form #4 for more information.**

Medication Name	Dosage of tab or liquid	Total Amount Taken Daily	Administering Info (method and time of day taken)



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Other Seizure Treatments

Device Type: _____

Date Implanted: ____/____/____

Dietary Therapy: _____

Date Begun: ____/____/____

Other Therapy or Treatment: _____

Any additional information for HISRA staff: _____

Signature of Legal Guardian

Date