SEIZURE ACTION PLAN FOR

______________________ (INSERT NAME HERE)

ABOUT

Name ______________________ Date of Birth ______________________

Doctors Name ______________________ Phone ______________________

Emergency Contact Name ______________________ Phone ______________________

Emergency Contact Name ______________________ Phone ______________________

Seizure Type / Name: ______________________

What Happens: ______________________

How Long It Lasts: ______________________

How Often: ______________________

Seizure Triggers:

- ☐ Missed Medicine
- ☐ Lack of Sleep
- ☐ Emotional Stress
- ☐ Physical Stress
- ☐ Missing meals
- ☐ Alcohol / Drugs
- ☐ Flashing Lights
- ☐ Menstrual Cycle
- ☐ Illness with high fever
- ☐ Response to specific food, or excess caffeine Specify: ____________
- ☐ Other Specify: ____________

DAILY TREATMENT PLAN

Seizure Medicine(s)

Name	How Much	How Often / When
Additional Treatment / Care: (i.e.: diet, sleep, devices etc.)		

CAUTION – STEP UP TREATMENT

Symptoms that signal a seizure may be coming on and additional treatment may be needed:

- ☐ Headache
- ☐ Staring Spells
- ☐ Confusion
- ☐ Dizziness
- ☐ Change in Vision / Auras
- ☐ Sudden Feeling of Fear or Anxiety
- ☐ Other Specify: ____________

Additional Treatment:

☐ Continue Daily Treatment Plan

- If missed medicine, give prescribed dose from above ASAP.
- Do not give a double dose or give meds closer than 6 hours apart.

☐ Change to: ____________ How Much: ____________ How Often / When: ____________

☐ Add: ____________ How Much: ____________ How Often / When: ____________

☐ Other Treatments / Care: (i.e.: sleep, devices): ______________________

SEIZURE ACTION PLAN

DANGER–GET HELP NOW

Follow Seizure First Aid Below

☐ Find adult trained on rescue medication:

Name: ____________________ Number: ____________________

☐ Record Duration and time of each seizure(s)

☐ Call 911 if:

- Child has a convulsive seizures lasting more than ___ minutes
- Child has repeated seizures without regaining consciousness
- Child is injured or has diabetes
- Child is having breathing difficulty

When EMS arrives, a medical provider will perform an individual assessment to determine appropriate next steps.

Rescue Therapy:

☐ Rescue therapy provided according to physician's order:

____

____

POST SEIZURE RECOVERY

Typical Behaviors / Needs After Seizure:

☐ Headache ☐ Drowsiness / Sleep ☐ Nausea ☐ Aggression ☐ Confusion / Wandering ☐ Blank Staring

☐ Other Specify: ______________

Reviewed / Approved by:

____

Physician Signature Date

____

Parent / Guardian Signature Date

SEIZURE FIRST AID

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LEARN MORE AND GET A DOWNLOADABLE VERSION OF THIS ACTION PLAN AT:

childneurologyfoundation.org/sudep

dannydid.org

epilepsy.com/sudep-institute

SEIZURE ACTION PLAN (SAP)

Name: ______________________________ Birth Date: ______________

Address: ______________________________ Phone: ______________

Emergency Contact/Relationship ______________________________ Phone: ______________

Seizure Information

Seizure Type	How Long It Lasts	How Often	What Happens

How to respond to a seizure (check all that apply) ☑

☐ First aid – **Stay. Safe. Side.**

☐ Give rescue therapy according to SAP

☐ Notify emergency contact

☐ Notify emergency contact at ______________

☐ Call 911 for transport to ______________

☐ Other ______________

First aid for any seizure

☐ **STAY** calm, keep calm, **begin timing seizure**

☐ Keep me **SAFE** – remove harmful objects, don't restrain, protect head

☐ **SIDE** – turn on side if not awake, keep airway clear, don't put objects in mouth

☐ **STAY** until recovered from seizure

☐ Swipe magnet for VNS

☐ Write down what happens ______________

☐ Other ______________

When to call 911

☐ Seizure with loss of consciousness longer than 5 minutes, not responding to rescue med if available

☐ Repeated seizures longer than 10 minutes, no recovery between them, not responding to rescue med if available

☐ Difficulty breathing after seizure

☐ Serious injury occurs or suspected, seizure in water

When to call your provider first

☐ Change in seizure type, number or pattern

☐ Person does not return to usual behavior (i.e., confused for a long period)

☐ First time seizure that stops on its' own

☐ Other medical problems or pregnancy need to be checked

When **rescue therapy** may be needed:

WHEN AND WHAT TO DO

If seizure (cluster, # or length) ______________

Name of Med/Rx ______________ How much to give (dose) ______________

How to give ______________

If seizure (cluster, # or length) ______________

Name of Med/Rx ______________ How much to give (dose) ______________

How to give ______________

If seizure (cluster, # or length) ______________

Name of Med/Rx ______________ How much to give (dose) ______________

How to give ______________

Care after seizure

What type of help is needed? (describe) ____

When is person able to resume usual activity? ____

Special instructions

First Responders: ____

____

Emergency Department: ____

____

Daily seizure medicine

Medicine Name	Total Daily Amount	Amount of Tab/Liquid	How Taken (time of each dose and how much)

Other information

Triggers: ____

Important Medical History ____

Allergies ____

Epilepsy Surgery (type, date, side effects) ____

Device: ☐ VNS ☐ RNS ☐ DBS Date Implanted ____

Diet Therapy ☐ Ketogenic ☐ Low Glycemic ☐ Modified Atkins ☐ Other (describe) ____

Special Instructions: ____

____

Health care contacts

Epilepsy Provider: ______________________ Phone: ______________________

Primary Care: ______________________ Phone: ______________________

Preferred Hospital: ______________________ Phone: ______________________

Pharmacy: ______________________ Phone: ______________________

My signature ______________________ Date ______________________

Provider signature ______________________ Date ______________________

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