**SEIZURE ACTION PLAN (SAP)**

Name: ———————————————————————————————————————————————————Birth Date: ———————————————————

Address: ——————————————————————————————————————————————————Phone: —————————————————————

Parent/Guardian: —————————————————————————————————————————————Phone: —————————————————————

Emergency Contact/Relationship ————————————————————————————————————Phone: —————————————————————

# Seizure Information

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Seizure Type How Long It Lasts How Often What Happens** | | | |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |



Protocol for seizure during school (check all that apply) 

 First aid – **Stay. Safe. Side.**  Contact school nurse at  Give rescue therapy according to SAP  Call 911 for transport to  Notify parent/emergency contact  Other

 First aid for any seizure

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

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



 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 **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



**Seizure Action Plan** *continued*

# Care after seizure

What type of help is needed? (describe)

When is student able to resume usual activity? 

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# 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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