# 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.**
- Give rescue therapy according to SAP
- Notify parent/emergency contact
- Contact school nurse 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 student 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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