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Seizure Action Plan (SAP)

Student: _____DOB: _____
Parent(s)/Guardian(s): _____ Date: _____
Home Phone: _____ Work: _____ Cell:_____

Seizure History

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 parents/guardians
- ☐ Call 911 for transport
- ☐ Other_____

FIRST AID FOR ANY SEIZURE

- **STAY** calm, keep calm, begin timing seizure
- Keep me **SAFE**-remove harmful objects, do not restrain, protect head
- **SIDE**-turn on side if not awake, keep airway clear, do not put objects in mouth
- **STAY** until recovered from seizure
- Write down what happens
- Other_____

When to call 911:

- ☐ Seizure with loss of consciousness longer than 5 minutes, not responding to rescue medication if available
- ☐ Repeated seizures longer than 10 minutes, no recovery between them, not responding to rescue medication if available
- ☐ Difficulty breathing after seizure
- ☐ Significant injury occurs or suspected, seizure in water

When to call Parent/Guardian or Provider first:

- ☐ Change in seizure type, number, or pattern
- ☐ Person does not return to usual behavior (ex. Remains confused for lengthy period of time)
- ☐ First time seizure that stops on its' own
- ☐ Other medical problems need to be checked

Daily seizure medication

Medication Name	Dosage	Time To Be Given

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When Rescue Therapy May Be Needed

WHEN AND WHAT TO DO

If Seizure (Cluster, # or length): _____
Medication: _____ Dose: _____
How to Give:_____

If Seizure (Cluster, # or length): _____
Medication: _____ Dose: _____
How to Give:_____

If Seizure (Cluster, # or length): _____
Medication: _____ Dose: _____
How to Give:_____

Seizure After Care

What type of help is needed? (describe) _____
_____

When is the person typically able to resume normal activity?_____
_____

Special Instructions

First Responders:_____
_____

Emergency Department: _____
_____

Important Information

Trigger:_____
Important Medical History:_____
Allergies: _____
Past Epilepsy Surgery? (type, date)_____
Device : ___ VNS ___ RNS ___ DBS Date Implanted : _____
Alternative Diet : _____
Special Instructions for School Staff: _____
_____

Health Care Contacts

Epilepsy Provider: _____ Phone: _____
Primary Care Provider: _____ Phone: _____
Preferred Hospital: _____ Phone: _____
Pharmacy: _____ Phone: _____

Emergency Contacts

Name: _____ Relationship: _____
Home Phone: _____ Cell Phone: _____
Name: _____ Relationship: _____
Home Phone: _____ Cell Phone: _____

Parent/Guardian Signature: _____ Date: _____

Provider Signature: _____ Date: _____