

SEIZURE ACTION PLAN (SAP)



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Name _____
Birthdate _____
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

- F **STAY** calm, keep calm, **begin timing seizure** Keep me
- F **SAFE** – remove harmful objects, don't restrain, protect head
- F **SIDE** – turn on side if not awake, keep airway clear, don't put objects in mouth
- F **STAY** until recovered from seizure
- F Swipe magnet for VNS
- F Write down what happens _____
- F Other _____

When to call 911

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

When to call your provider first

- F Change in seizure type, number or pattern
- F Person does not return to usual behavior (i.e., confused for a long period)
- F First time seizure that stops on its' own
- F 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 _____

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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 _____