SEIZURE ACTION PLAN (SAP)

Epilepsy Association

Name: _____ Birth Date: _____

Address: _____ Phone: _____

Emergency Contact/Relationship: 1. _____ Phone: _____

2. _____ Phone: _____

3. _____ 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
- ☐ Give rescue therapy according to SAP
- ☐ Notify emergency contact
- ☐ Notify emergency contact at _____
- ☐ Call 911 for transport to _____
- ☐ Other _____

When Rescue Therapy may be needed (when and what to do):

Back-to-Back, Number of Seizures, or Length: _____

Name of Med/Rx: _____ Amount to give (Dose): _____

How to give: _____

First Aid for Seizures

- ☐ **Stay** Calm and **start timing seizure**
- ☐ Keep person **safe**, remove potential hazards
- ☐ Turn on **side** to clear airway, cushion head
- ☐ **Don't** put anything in mouth
- ☐ Do **not** restrain or hold down
- ☐ Stay until **recovered** from seizure
- ☐ Write down what happens _____
- _____
- ☐ Other _____
- _____

When to call 911

- ☐ Seizure last more than 5 minutes, not responding to seizure rescue med
- ☐ First Seizure or Pregnant
- ☐ Back-to-back seizures, more then 3, no recovery in-between
- ☐ Seizure happens in water or serious injury suspected
- ☐ Difficult breathing after seizure

When to call your provider/emergency contact first

- ☐ Change in seizure type, number or pattern
- ☐ Person does not return to usual behavior (i.e., confused for a long period)
- ☐ Other medical conditions or pregnancy need to be checked
- ☐ First time seizure that stops on its' own

Seizure Action Plan *continued*

Care After Seizure

What type of help should be provided? (describe) _____

_____

How long until person can be back to normal activity? _____

Any Special Instructions

First Responders: _____

_____

Emergency Department: _____

_____

Daily Seizure Medication

Medication Name	Total Daily Amount	Daily Doses Amount Tab/Liquid	Time Taken (dose, amount)

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) _____

_____

_____

Health Care Contacts

Epilepsy Physician: _____ Phone: _____

Primary Care: _____ Phone: _____

Preferred Hospital: _____ Phone: _____

Pharmacy: _____ Phone: _____

My Signature: _____ Date: _____

Provider Signature: _____ Date: _____