I AM HAVING A SEIZURE HERE IS WHAT TO DO

A SEIZURE ACTION PLAN (SAP)

PERSONAL INFORMATION

Full Name		
Address		
Phone	Email	DoB
Emergency Contact/Relationship		Phone

SEIZURE FIRST AID

- Stay calm, most seizures only last a few minutes.
- Start timing the seizure when it starts.
- Prevent injury by moving any nearby objects out of the way.
- Make the person as comfortable as possible and turn on side.
- Do not hold the person down.
- Do not put anything in the person's mouth.
- Do not give the person water, pills, or food until fully alert.
- Be sensitive and supportive, and ask others to do the same.
- Rescue Med:

When to call 911:

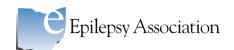
- A seizure lasts longer than 5 minutes and not responding to rescue med (if available)
- · A repeated seizure happens soon after the first with no recovery between them
- · A serious injury occurs during the seizure

First Responders & Emergency Department:

- Seizure takes place in water
- The person stops breathing for longer than 30 seconds

RESCUE THERAPY

WHEN AND WHAT TO DO
Rescue Med: O Nayzilam O Valtoco O Diastat O Other:
Give if:
How much to give (dose): ○ 5MG ○ 10MG ○ 15MG ○ 20MG ○ Other:
How to give:
POST SEIZURE CARE What type of help is needed? Describe
When can usual activity be resumed?
SPECIAL INSTRUCTIONS



HERE IS MORE ON MY SEIZURES

SEIZURE INFORM	MATION			
		Seizure Type		
O Tonic-clonic (Gran	d Mal) OAbsence (Focal Onset Aware (Si	mple Partial)	
O Focal Onset Impai	ired Awareness (Complex	Partial) OPsychogen	ic Non-epileptic (PNES) Other:	
HOW LONG IT LASTS HOW OFTEN			WHAT HAPPENS	
	_			
	_	_		
AILY SEIZURE M	IEDICINE			
MEDICINE NAME	TOTAL DAILY AMOUNT	AMOUNT OF TAB/LIQUID	HOW TAKEN (TIME OF EACH DOSE AND HOW MUCH)	
			(
riggers:		THER INFORI	MATION	
iiportant ivieai	carristory			
allergies:				
 pilepsy Surger	y (type, date, side	e effects):		
1 1 7 3	, (11 , , ,	,		
Device: O VNS (⊃ RNS ⊝ DBS Da:	te Implanted:		
evice Instructi	ons:			
Enilonal Provid		ALTH CARE (
Epilepsy Provider:				
Primary Care:				
Preferred Hosp		D HAC DEEN	Phone:	
My Signature:			N REVIEWED BY: Date:	
Provider Signature:			Date:	
Guardian (if applicable):			Date:	
School Nurse (if applicable):			 Date:	

Epilepsy Association