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

RESCUE THERAPY

WHEN AND WHAT TO DO

Rescue Med: ☐ Nayzilam ☐ Valtoco ☐ Diastat ☐ 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

First Responders & Emergency Department: _____

HERE IS MORE ON MY SEIZURES

SEIZURE INFORMATION

Seizure Type
☐ Tonic-clonic (Grand Mal) ☐ Absence ☐ Focal Onset Aware (Simple Partial)
☐ Focal Onset Impaired Awareness (Complex Partial) ☐ Psychogenic Non-epileptic (PNES) ☐ Other: _____

HOW LONG IT LASTS	HOW OFTEN	WHAT HAPPENS

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: _____

Device Instructions: _____

Diet Therapy: _____

HEALTH CARE CONTACTS

Epilepsy Provider: _____ Phone: _____

Primary Care: _____ Phone: _____

Preferred Hospital: _____ Phone: _____

THIS S.A.P. HAS BEEN REVIEWED BY:

My Signature: _____ Date: _____

Provider Signature: _____ Date: _____

Guardian (if applicable): _____ Date: _____

School Nurse (if applicable): _____ Date: _____