

SEIZURE ACTION PLAN FOR

_____ (INSERT NAME HERE)



Attach Student Photo

ABOUT

Name _____ Date of Birth _____

Doctors Name _____ Phone _____

Emergency Contact Name _____ Phone _____

Emergency Contact Name _____ Phone _____

Seizure Type/Name: _____

What Happens: _____

How Long It Lasts: _____

How Often: _____

Seizure Triggers:

- Missed Medicine Lack of Sleep Emotional Stress Physical Stress Missing meals
 Alcohol/Drugs Flashing Lights Menstrual Cycle Illness with high fever
 Response to specific food, or excess caffeine Specify: _____ Other Specify: _____

DAILY TREATMENT PLAN

Seizure Medicine(s)

Name	How Much	How Often/When

Additional Treatment/Care: (i.e.: diet, sleep, devices etc.)

! CAUTION – STEP UP TREATMENT

Symptoms that signal a seizure may be coming on and additional treatment may be needed:

- Headache Staring Spells Confusion Dizziness Change in Vision/Auras
 Sudden Feeling of Fear or Anxiety Other Specify: _____

Additional Treatment:

- Continue Daily Treatment Plan
• If missed medicine, give prescribed dose from above ASAP.
• Do not give a double dose or give meds closer than 6 hours apart.
- Change to: _____ How Much: _____ How Often/When: _____
- Add: _____ How Much: _____ How Often/When: _____
- Other Treatments/Care: (i.e.: sleep, devices): _____

SEIZURE ACTION PLAN

DANGER-GET HELP NOW

Follow Seizure First Aid Below

Find adult trained on rescue medication:

Name: _____ Number: _____

Record Duration and time of each seizure(s)

Call 911 if:

- Child has a convulsive seizures lasting more than ___ minutes
- Child is injured or has diabetes
- Child has repeated seizures without regaining consciousness
- Child is having breathing difficulty

When EMS arrives, a medical provider will perform an individual assessment to determine appropriate next steps.

Rescue Therapy:

Rescue therapy provided according to physician's order:

POST SEIZURE RECOVERY

Typical Behaviors/Needs After Seizure:

Headache Drowsiness/Sleep Nausea Aggression Confusion/Wandering Blank Staring

Other Specify: _____

Reviewed/Approved by:

Physician Signature _____

Date _____

Parent/Guardian Signature _____

Date _____

SEIZURE FIRST AID



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