SEIZURE ACTION PLAN (SAP)

Name: ______________________________ **Birth Date:** ______________

Address: ______________________________ **Phone:** ______________

Emergency Contact/Relationship ______________________________ **Phone:** ______________

Seizure Information

Seizure Type	How Long It Lasts	How Often	What Happens

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 ______________________________

If seizure (cluster, # or length) ______________________________

Name of Med/Rx ______________ **How much to give (dose)** ______________

How to give ______________________________

If seizure (cluster, # or length) ______________________________

Name of Med/Rx ______________ **How much to give (dose)** ______________

How to give ______________________________

Care after seizure

What type of help is needed? (describe) ______________________________

When is person 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:** ______________________________

Parents / Legal Guardians Please Read Carefully: *By signing below, I understand and agree to the following*:

- I understand that all prescribed medications must be in the original container issued by the pharmacist with the most recent prescription label.
- I will notify the school when the medication is discontinued or the dosage changes.
- I give permission for the principal, school nurse(s), and/or health services to share this information with individuals who have responsibility for my child.
- I give BCSD Health Services my permission to contact the prescribing Licensed Health Care Provider and prescribing pharmacy in relation to this prescription medication.
- I am responsible for replacing medication before the expiration date.
- I give my permission for designated BCSD staff to administer this medication to my child according to district requirements
- I understand that my child will lose the privilege to self-medicate if he or she endangers him- or herself or another student by misusing the medication(s).

Parent signature ______________________________ **Date** ______________________________

Provider signature ______________________________ **Date** ______________________________

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