FY 2023 - 2024
SEIZURE ACTION PLAN
(SAP)

Name:	
	(First Name, Middle Name and Last Name)
Address:	
	(Street #, Street Name, City, State and Zip Code)
Phone:	
EMERGENCY CONTACT RELATIONSHIP	
Primary Emergency Contact:	
	(First Name, Middle Name and Last Name)
Address:	
	(Street #, Street Name, City, State and Zip Code)
Home Phone:	
Mobile Phone:	
Relation:	

SEIZURE INFORMATION	
Seizure Type:	
How Long It Lasts:	
How Often:	
What happens:	

HOW TO RESPOND TO A SEIZURE
• ***First Aid – Stay. Safe. Side***
• ***Give rescue therapy according to SAP (Seizure Action Plan)***
• ***Notify emergency contact***
• ***Other***

FIRST AID FOR ANY SEIZURE
• *Stay calm, keep calm,* ***begin timing seizure***
• *Keep me* ***SAFE*** *remove harmful objects, don't restrain, protect head*
• ***SIDE*** *– turn on side if not awake, keep airway clear, put objects in mouth*
• *STAY until recovered from seizure*
• *Write down what happens*

WHEN TO CALL 911
• *Seizure with loss of consciousness longer than 5 minutes, not responding to rescue med if available.*
• *Repeated seizures longer than 10 minutes, no recovery between them, not responding to rescue med if available.*
• *Difficulty breathing after seizure.*
• *Serious injury occurs or suspected, seizure in water*
WHEN TO CALL YOUR PROVIDER FIRST
• ***Change in seizure type, number, or pattern***
• ***Person does not return to usual behavior (i.e., confused for a long period)***
• ***First time seizure that stops on its own***
• ***Other medical problems or pregnancy need to be checked***

WHEN RESCUE THERAPY MAY BE NEEDED	
WHEN AND WHAT TO DO	
If seizure (cluster, # or length)	
Name of Med/Rx	
How much to give	
How to give	

CARE AFTER SEIZURE	
What type of help is needed:	
When is person able to resume usual activity:	
Special Instructions:	
First Responders:	
Emergency Department:	
Daily seizure medicine:	
Triggers:	
Medical History:	

OTHER INFORMATION (Continued)	
Past Medical History:	
Diagnosis:	
Allergies:	
Epilepsy Surgery:	
Device:	
Diet Therapy:	
Special Instructions:	
Preferred Hospital:	

Physician Signature:		**Date Signed:**	
Parent Signature:		**Date Signed:**	

Nursing Supervisor Signature:		**Date Signed:**	

Print Reset Form