EPILEPSY FOUNDATION
Eastern Pennsylvania

MY SEIZURE PLAN

Epilepsy Foundation Eastern PA
919 Walnut Street, Suite 700
Philadelphia, PA 19107

Name: ______________________ Birth Date: ______________
Address: ______________________ Phone: ______________
1st Emergency Contact: ______________________ Relation: ______________
Phone(s): ______________________ Email: ______________
2nd Emergency Contact: ______________________ Relation: ______________
Phone(s): ______________________ Email: ______________

SEIZURE INFORMATION

Seizure Type/Nickname	What Happens	How Long It Lasts	How Often

TRIGGERS

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DAILY SEIZURE MEDICINE

Medicine Name	Total Daily Amount	Amount of Tab/Liquid	How Taken (time of each dose and how much)

OTHER SEIZURE TREATMENTS

Device Type:______________ Model:__________ Serial#:__________ Date Implanted:__________
Diatery Therapy:______________________________ Date Begun:__________
Special Instructions:______________________________
Other Therapy:______________________________