SEIZURE ACTION PLAN (SAP)

GENERAL INFORMATION

School: **School Year:**

Child's Name		**Date of Birth**
Parent/Guardian	**Phone**	**Cell**
Other Emergency Contact	**Phone**	**Cell**
Treating Physician	**Phone**	**Allergies**
Significant Medical History		
Describe any special considerations, limitations or precautions needed (regarding activities, sports, trips, food, etc.)		

SEIZURE INFORMATION - *Please refer to the FPS SEIZURE QUESTIONNAIRE FOR PARENT/GUARDIAN for more info.*

Seizure Type?	How Long?	How Often?	What happens?

Epilepsy Surgery (type, date, side effects)?	**Child's Response or Care Needed AFTER Seizure?**

Device: ❑ **VNS** ❑ **RNS** ❑ **DBS** **Date Implemented** _____
Instructions:

SEIZURE RESPONSE - How to respond to a seizure (check all that apply)

- ❑ First aid – **Stay. Safe. Side.**
- ❑ Give rescue therapy according to this SAP (or SAP from Physician)
- ❑ Notify emergency contact from above
- ❑ Call 911 for transport to: _____
- ❑ 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, don't put objects in mouth
- ❑ **STAY** until recovered from seizure
- ❑ Swipe magnet for VNS
- ❑ Write down what happens on **MY SEIZURE EVENT DIARY**
- ❑ Other _____

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

EMERGENCY MEDICATION INSTRUCTIONS IF SEIZURE OCCURS

For cluster # or length	Give Medication (Rx name)	Dose	Route

Parent/Guardian Signature: _____ Date _____

Treating Provider Signature: _____ Date _____