



HEALTH SERVICES DEPARTMENT SEIZURE ACTION PLAN (SAP)

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

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

HOW TO RESPOND TO A SEIZURE	
<ul style="list-style-type: none"> • First Aid – Stay. Safe. Side • Give rescue therapy according to SAP (Seizure Action Plan) • Notify emergency contact • Other 	

FIRST AID FOR ANY SEIZURE	
<ul style="list-style-type: none"> • 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, DO NOT put objects in mouth • STAY until recovered from seizure • Write down what happens 	

WHEN TO CALL 911	
<ul style="list-style-type: none"> • 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	
<ul style="list-style-type: none"> • 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

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:	