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

____
____

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: ______________________

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SEIZURE FIRST AID

- ☐ Keep calm, provide reassurance, remove bystanders
- ☐ Keep airway clear, turn on side if possible, nothing in mouth
- ☐ Keep safe, remove objects, do not restrain
- ☐ Time, observe, record what happens
- ☐ Stay with person until recovered from seizure
- ☐ Other care needed:______________________________

WHEN SEIZURES REQUIRE ADDITIONAL HELP

Type of Emergency (long, clusters or repeated events)	Description	What to Do

"AS NEEDED" TREATMENTS (VNS magnet, medicines)

Name	Amount to Give	When to Give	How to Give

CALL 911 OR SEEK EMERGENCY MEDICAL ATTENTION IF ...

- ☐ Generalized seizure longer than 5 minutes
- ☐ Two or more seizures without recovering between seizures
- ☐ "As needed" treatments don't work
- ☐ Injury occurs or is suspected, or seizure occurs in water
- ☐ Breathing, heart rate or behavior doesn't return to normal
- ☐ Unexplained fever or pain, hours or few days after a seizure
- ☐ Other care needed:______________________________

HEALTH CARE CONTACTS

Epilepsy Doctor:______________________ Phone: ______________________
Nurse/Other Health Care Provider:______________________ Phone: ______________________
Preferred Hospital:______________________ Phone: ______________________
PCP or Other Doctor:______________________ Phone: ______________________
Pharmacy:______________________ Phone: ______________________

SPECIAL INSTRUCTIONS: ______________________________

My signature ______________ **Provider signature**______________ **Date** ______________