SEIZURE ACTION PLAN (SAP)

EPILEPSY FOUNDATION

Name: _____ Birth Date: _____

Address: _____ Phone: _____

Emergency Contact/Relationship: _____ Phone: _____

Seizure Information

Seizure Type	How Long It Lasts	How Often	What Happens

How to respond to a seizure (check all that apply)

- ☐ First aid – **Stay. Safe. Side.**
- ☐ Give rescue therapy according to SAP
- ☐ Notify emergency contact
- ☐ Notify emergency contact at _____
- ☐ 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

_____

- ☐ 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

When **rescue therapy** may be needed:

When and What to do

If seizure (cluster, # or length) _____

Name of Med/Rx _____ How much to give (dose) _____

How to give _____

If seizure (cluster, # or length) _____

Name of Med/Rx _____ How much to give (dose) _____

How to give _____

If seizure (cluster, # or length) _____

Name of Med/Rx _____ How much to give (dose) _____

How to give _____

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Care after seizure

What type of help is needed? (describe) _____

When is person able to resume usual activity? _____

Special instructions

First Responders: _____

_____

Emergency Department: _____

_____

Daily seizure medicine

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

Other information

Triggers:

Important Medical History:

Allergies:

Epilepsy Surgery (type, date, side effects) _____

Device: ☐ VNS ☐ RNS ☐ DBS Date Implanted _____

Diet Therapy: ☐ Ketogenic ☐ Low Glycemic ☐ Modified Atkins ☐ Other (describe) _____

Special Instructions: _____

_____

Health care contacts

Epilepsy Provider: _____ Phone: _____

Primary Care: _____ Phone: _____

Preferred Hospital: _____ Phone: _____

Pharmacy: _____ Phone: _____

My signature: _____ Date _____

Provider Signature: _____ Date: _____

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Acute Seizure Action Plan (ASAP)

This ASAP can be used in conjunction with your longer Seizure Action Plan. Having this shortened version may be helpful in the event of a seizure.

Name:	Birth date:	Today's date:
Care partner phone numbers:	Provider name/facility: Provider phone numbers: Telemedicine:	

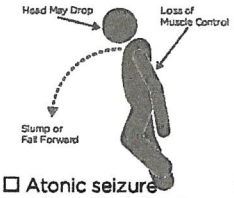
Usual Seizure Pattern

Triggers:

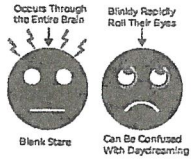
Pattern of seizures:

What the seizures normally look like (Check all that apply)

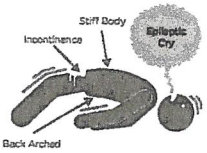
Describe:



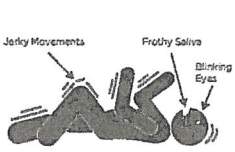
☐ Atonic seizure (also called drop)



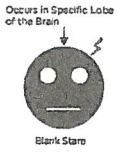
☐ Absence seizure (also called petit mal)



☐ Tonic seizure



☐ Clonic seizure



☐ Focal impaired awareness seizure (also called complex partial)

NOTES:

Care

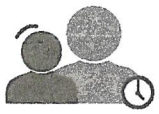
Standard Care Needed

If this happens, _____ provide standard care



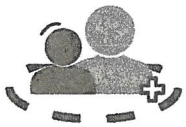
Time the seizure

NOTES:



STAY with person

NOTES:



Keep person SAFE.

NOTES:



Turn the person onto their SIDE

NOTES:



Keep a record

NOTES:

Provide Rescue Treatment

If this happens, _____ provide standard care (above) and rescue treatment



☐ Rectum



☐ Nose



☐ Mouth

Specific instructions: _____

☐ Other: _____

Call for Emergency Help

If any of these happen,



☐ Seizure longer than ____ minutes



☐ Unusual seizure



☐ Injury/Blue lips

☐ Other:

Get help now





NOTES:

Healthcare provider name/phone number:

Healthcare Provider Authorization

Signature: _____ Provider Printed Name: _____ Date: _____ For use from: _____ to: _____

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THE WARDLAW+HARTRIDGE SCHOOL AUTHORIZATION FOR MEDICATION IN SCHOOL

The following section is to be completed by the **PARENT**: School Year: 20__ - 20__

Child's Name:_____ *Date of birth:*_____ *grade:*_____

I request that my child be assisted in taking the medicine described below at school by authorized persons. The medication prescribed below is needed during school hours for my child to properly function and cannot be given at home. Herbal and dietary supplements are not considered medications and cannot be given in school. All medication must be **brought to school by a parent/guardian, in an original unopened labeled pharmacy container**, including for over-the-counter medications also. Please check and note expiration date. At the conclusion of treatment/school year (whichever is first) parent/guardian **must pick up** medication or it will be **discarded** on the last day of school. Changes to regime must be put in writing by prescribing physician. I agree that information may be shared with appropriate school personnel on a need to know basis. Neither the Wardlaw+Hartridge School employees or school nurse, and/or the Educational Services Commission of NJ's employees or nurse shall be responsible for any liability as a result of any injury arising from the authorized administration of medication.

_____ _____ _____

Date PRINT NAME parent/guardian Parent/Guardian Signature

Student s 18 and over must sign form themselves

The following section is to be completed by the **PHYSICIAN**:

Child's name:_____ DOB:_____ Diagnosis:_____

Medication: _____ Dosage: _____ Route: _____

If medicine is to be given daily, at what time? _____

If medicine is to be given "when needed," describe indications: _____

How soon can it be repeated? _____

Length of time this treatment is recommended: _____

Print Physician's Name: _____

Signature of physician: _____

Address/telephone number_____

Date: _____

Physician's Stamp