

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)	
 ☐ Atonic seizure (also called drop)	 ☐ Absence seizure (also called petit mal)
 ☐ Tonic seizure	 ☐ Clonic seizure
 ☐ Focal impaired awareness seizure (also called complex partial)	
Describe: _____	
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	☐ Other: _____	
Specific instructions: _____				

Call for Emergency Help				
If any of these happen,				Get help now
 ☐ Seizure longer than _____ minutes	 ☐ Unusual seizure	 ☐ Injury/Blue lips	☐ Other: _____	 911
NOTES: _____				Healthcare provider name/phone number: _____

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