

Acute Seizure Action Plan

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



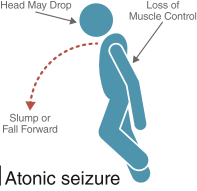
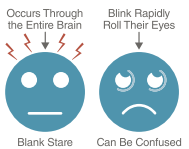
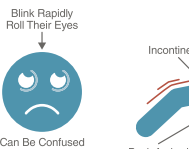
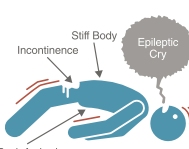
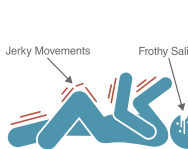
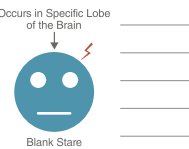
Usual Seizure Pattern

Triggers: _____

Pattern of seizures: _____

Allergies: _____

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

 Head May Drop Loss of Muscle Control Slump or Fall Forward	 Occurs Through the Entire Brain Blank Stare	 Blink Rapidly Roll Their Eyes Can Be Confused With Daydreaming	 Incontinence Stiff Body Back Arched Epileptic Cry	 Jerky Movements Frothy Saliva Blinking Eyes	 Occurs in Specific Lobe of the Brain Blank Stare
---	--	---	--	---	---

☐ 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: _____	 Keep person safe NOTES: _____	 Don't restrict NOTES: _____	 Stay with person 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: _____
---	---	--	--

NOTES: _____

Get help now

 Call Healthcare Provider if: _____	 Call for Emergency Help if: _____
---	--

NOTES: _____

Healthcare Provider Authorization

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