

SEIZURE ACTION PLAN (SAP)



ENDEPILEPSY

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 to give _____ How much to give (dose) _____

If seizure (cluster, # or length) _____

Name of Med/Rx _____

How to give _____ How much to give (dose) _____

If seizure (cluster, # or length) _____

Name of Med/Rx _____

How to give _____ How much to give (dose) _____

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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END EPILEPSY