

SEIZURE ACTION PLAN (SAP)



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 _____

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: _____



HEALTH SERVICES

Authorization to Administer Prescription and Non-Prescription Medication

Student's Name: _____ Date of Birth: _____

School: _____ Grade: _____

Medication: _____ Dosage: _____ Route: _____ Time: _____

Reason for Medication: _____ Start Date: ____/____/____ End Date: ____/____/____

THIS SECTION IS REQUIRED FOR PRESCRIPTION MEDICATIONS ONLY

Physician Signature/Or Copy of Current Prescription Label

I have prescribed the medication(s) listed above and authorize the school nurse or the principal's designee to administer them as prescribed, with time adjustments to accommodate lunches, late arrivals, early dismissals, etc.

Physician Signature
Must be signed for the student to self-carry (e.g., inhaler, EpiPen)

This student has demonstrated the ability to follow instructions regarding the safe and appropriate use of this emergency medication and should be permitted to carry it. Controlled substances are NOT permitted to be carried by students.

Please send the following medication(s) home with the student at the end of the school year.

*Controlled substances **WILL NOT** be sent home with the student. Controlled substances must be picked up by a parent, guardian, or an adult who is at least 18 years of age, with written permission from the parent or guardian.

☐ Benadryl ☐ Epinephrine (Auvi-Q, EpiPen, Neffy, etc.) ☐ Inhaler

PARENT AGREEMENT/AUTHORIZATION:

- I authorize the school nurse and/or the principal's designee to administer the prescribed medication to my child as prescribed/directed by a licensed healthcare provider.
- I understand that it is the parent's/guardian's responsibility to supply the medication in its original, properly labeled container. **Prescription medications must have a pharmacy label.**
- I agree to replace any medication before or by the expiration date.
- I understand that any changes to the medication, dosage, or administration frequency require a new Authorization to Administer Medication form, including a physician's signature or updated pharmacy label (*for prescription medications*).
- A new Authorization to Administer Medication form must be submitted each school year.
- Students are not permitted to carry or transport medications without a current Authorization to Administer Medication form on file.
- Medications not picked up by the end of the school year will be properly disposed of.
- I agree to notify the school nurse or principal's designee if the medication should not be administered for any reason (e.g., late arrival, early dismissal, discontinuation).

Parent/Guardian Name (*printed*): _____

Parent/Guardian Signature: _____

Date: _____