Place logo here

SEIZURE ACTION PLAN

Place Photo here

NAME: _____ **Date of Birth:** _____

Parent/Guardian:_____ Phone: _____ Cell:_____

Parent/Guardian:_____ Phone: _____ Cell:_____

Other contact:_____ Phone: _____ Cell:_____

Primary provider:_____ Phone: _____

Specialist:_____ Phone: _____

Hospital Preference: _____

Significant medical history:_____

Daily and Emergency Medicines:

Daily Medicines	Dose & Time of Day Given	Common Side Effects & Special Instructions

Name of medicine	How to give & How much	When to give medicine	Common Side Effects / Special Instructions

Do I have a **Vagus Nerve Stimulator (VNS)?** YES NO

If YES, Describe magnet use_____

SPECIAL CONSIDERATIONS & SAFETY PRECAUTIONS: *(regarding triggers, activities, sports, trips, etc.)*

SEIZURE INFORMATION:

What do I need to avoid to reduce my seizures? _____

What my seizure looks like?	*What do I need for this?*	*What I need after this?*
	Basic Seizure First Aid: ✓ Stay calm & track time ✓ Keep me/my child safe ✓ Do not restrain me ✓ Do not put anything in mouth ✓ Stay with my/my child until fully awake ✓ Record seizure in log For tonic-clonic (grand mal) seizure: ✓ Protect head ✓ Keep airway open/watch breathing ✓ Turn me/my child on side	
What is a "seizure emergency" for me	**A seizure is generally considered an emergency when:** ✓ A convulsive (tonic-clonic) seizure lasts longer than 5 minutes ✓ I/my child has repeated seizures without regaining consciousness ✓ I/my child has a first time seizure ✓ I/my child is injured or has diabetes ✓ I/my child has breathing difficulties ✓ I/my child has a seizure in water	☐ Call 911 for transport to _____ ☐ Notify parent or this emergency contact – Name:_____Number:_____ ☐ Notify doctor ☐ Administer emergency medicines as indicated above ☐ Other_____

Please share this information with anyone at school.

Physician Name and Signature:_____ **Clinic:**_____ **Date:**_____

Parent Name and Signature:_____ **Date:**_____

(Form developed by school nurses in the state of Washington)