

# SEIZURE ACTION PLAN (SAP)



END EPILEPSY

Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
Parent/Guardian: \_\_\_\_\_ Phone: \_\_\_\_\_  
Emergency Contact/Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

## Seizure Information

Seizure Type	How Long It Lasts	How Often	What Happens

### Protocol for seizure during school (check all that apply) ☒

- |   |  |
|---|--|
| <input type="checkbox"/> First aid – <b>Stay. Safe. Side.</b> | <input type="checkbox"/> Contact school nurse at _____   |
| <input type="checkbox"/> Give rescue therapy according to SAP | <input type="checkbox"/> Call 911 for transport to _____ |
| <input type="checkbox"/> Notify parent/emergency contact      | <input type="checkbox"/> 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 student 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 \_\_\_\_\_