

SEIZURE ACTION PLAN FOR

_____ (INSERT NAME HERE)



Attach Photo

ABOUT

Name _____ Date of Birth _____

Doctor's Name (Primary physician to call when seizure occurs) _____ Phone _____

Emergency Contact Name _____ Phone _____

Emergency Contact Name _____ Phone _____

Seizure Type(s) / Name(s): _____

What Happens: _____

How Long It Lasts: _____

How Often: _____

Seizure Triggers*:

**If multiple seizure types, consider talking to your school about additional details they may need to know.*

- | | | | | |
|--|---|--|--|--|
| <input type="checkbox"/> Missed Medicine | <input type="checkbox"/> Emotional Stress | <input type="checkbox"/> Alcohol/Drugs | <input type="checkbox"/> Menstrual Cycle | <input type="checkbox"/> Missing meals |
| <input type="checkbox"/> Lack of Sleep | <input type="checkbox"/> Physical Stress | <input type="checkbox"/> Flashing Lights | <input type="checkbox"/> Illness with high fever | |
| <input type="checkbox"/> Response to specific food, or excess caffeine | Specify: _____ | | <input type="checkbox"/> Other | Specify: _____ |

DANGER – GET HELP NOW

- Find adult trained on rescue medication:
Name: _____ Number: _____
- Record Duration and time of each seizure(s)

- Call 911 if:
- Child has a convulsive seizures lasting more than ____ minutes
 - Child is injured or has diabetes
 - Child has repeated seizures without regaining consciousness
 - Child is having breathing difficulty

Other reasons to call 911: _____

When EMS arrives, a medical provider will perform an individual assessment to determine appropriate next steps. Rescue Therapy:

- Rescue therapy provided according to physician's order:

Preferred hospital: _____

SEIZURE ACTION PLAN

DAILY TREATMENT PLAN

Seizure Medicine(s) (Ensure school has full prescription instructions.)

Name	How Much	How Often/When
Additional Treatment/Care: (i.e.: diet, sleep, devices etc.)		

! CAUTION – STEP UP TREATMENT

Some symptoms can signal that a seizure may be coming on. _____ has the following symptoms as warning sign for an impending seizure and may need additional treatment

- Headache
- Staring Spells
- Confusion
- Dizziness
- Change in Vision/Auras
- Sudden Feeling of Fear or Anxiety
- Other Specify: _____

Additional Treatment:

- Continue Daily Treatment Plan
 - If missed medicine, give prescribed dose from above ASAP.
 - Do not give a double dose or give meds closer than 6 hours apart.
- Change to: _____ How Much: _____ How Often/When: _____
- Add: _____ How Much: _____ How Often/When: _____
- Other Treatments/Care: (i.e.: sleep, devices, safe position): _____

POST SEIZURE RECOVERY

Typical Behaviors/Needs After Seizure:

- Headache
- Drowsiness/Sleep
- Nausea
- Aggression
- Confusion/Wandering
- Blank Staring
- Other Specify: _____

Reviewed/Approved by: _____

Physician Signature Date

Parent/Guardian Signature Date

LEARN MORE AT:



childneurologyfoundation.org/sudep



dannydid.org



epilepsy.com/sudep-institute

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