



SEIZURE ACTION PLAN

Effective Date: _____

THIS PATIENT IS BEING TREATED FOR A SEIZURE DISORDER. THE INFORMATION BELOW SHOULD ASSIST YOU IF A SEIZURE OCCURS.

Patient's Name: _____

Date of Birth: _____

Emergency contact: _____

Phone: _____ Cell: _____

Treating Physician: _____

Phone: _____

Significant medical history: _____

SEIZURE INFORMATION:

Seizure Type	Average length	Average Frequency	Description

Patient triggers or warning signs: _____

Patient's reaction to seizure: _____

BASIC FIRST AID: CARE & COMFORT: *(Please describe basic first aid procedures)*

- Basic Seizure First Aid:**
- ✓ Stay calm & track time
 - ✓ Keep patient safe
 - ✓ Do not restrain
 - ✓ Do not put anything in mouth
 - ✓ Stay with patient until fully conscious
 - ✓ Record seizure in log
- For tonic-clonic (grand mal) seizure:**
- ✓ Protect head
 - ✓ Keep airway open/watch breathing
 - ✓ Turn patient on side
- A Seizure is generally considered an Emergency when:**
- ✓ A convulsive (tonic-clonic) seizure lasts longer than 5 minutes
 - ✓ Patient has repeated seizures without regaining consciousness
 - ✓ Patient has a first time seizure
 - ✓ Patient is injured or has diabetes
 - ✓ Patient has a first-time seizure
 - ✓ Patient has breathing difficulties

EMERGENCY RESPONSE:

A "seizure emergency" for this patient is defined as: _____

Seizure Emergency Protocol: *(Check all that apply and clarify below)*

- Notify emergency contact at _____
- Call 911 for transport to _____
- Notify doctor
- Administer emergency medications as indicated below
- Other _____

TREATMENT PROTOCOL:

Daily/Rescue Medication	Dosage & Time of Day Given	Common Side Effects & Special Instructions

Does patient have a **Vagus Nerve Stimulator (VNS)**? YES NO

If YES, Describe magnet use _____

SPECIAL CONSIDERATIONS & SAFETY PRECAUTIONS: *(regarding activities, daily living, etc.)*

Physician Signature: _____ Date: _____

Patient Signature: _____ Date: _____