SEIZURE ACTION PLAN (SAP)

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) ☑

- ☐ First aid – **Stay. Safe. Side.**
- ☐ Give rescue therapy according to SAP
- ☐ Notify parent/emergency contact
- ☐ Contact school nurse 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 the head
- ☐ **SIDE** – turn on side if not awake, keep airway clear, don't put objects in mouth
- ☐ **STAY** until recovered from the 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 meds if available.
- ☐ Repeated seizures longer than 10 minutes, no recovery between them, not responding to rescue meds 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 the 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: _____

Student's Understanding of and Ability to Manage Disorder: _____

_____

Health care contacts

Epilepsy Provider: _____ Phone: _____

Primary Care: _____ Phone: _____

Preferred Hospital: _____ Phone: _____

Pharmacy: _____ Phone: _____

Parent/Guardian signature indicates acknowledgment and release for sharing medical information between our student's physician and other health care providers and authorizing the designated school nurse to share medical information with other school employees as necessary.

Parent/Guardian signature: _____ Date: _____

Provider signature: _____ Date: _____