# Seizure Action Plan

**About**

<table>
<thead>
<tr>
<th>Name</th>
<th>Date of Birth</th>
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<tr>
<th>Doctors Name</th>
<th>Phone</th>
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<th>Emergency Contact Name</th>
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**Seizure Type/Name:**

What Happens:

How Long It Lasts:

How Often:

**Seizure Triggers:**

- Missed Medicine
- Lack of Sleep
- Emotional Stress
- Physical Stress
- Missing meals
- Alcohol/Drugs
- Flashing Lights
- Menstrual Cycle
- Illness with high fever
- Other Specify:
- Response to specific food, or excess caffeine
  Specify: ____________
- Illness with high fever
- Other Specify: ____________
- Emotional Stress
- Physical Stress
- Missing meals
- Alcohol/Drugs
- Flashing Lights
- Menstrual Cycle
- Illness with high fever
- Other Specify: ____________

## Daily Treatment Plan

**Seizure Medicine(s)**

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

**CAUTION – Step up Treatment**

Symptoms that signal a seizure may be coming on and additional treatment may be needed:

- 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): _____________________________
SEIZURE ACTION PLAN

DANGER—GET HELP NOW
Follow Seizure First Aid Below

☐ 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 has repeated seizures without regaining consciousness
  • Child is injured or has diabetes
  • Child is having breathing difficulty

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:
______________________________________________________________________________________________________________________________________
______________________________________________________________________________________________________________________________________

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 __________

SEIZURE FIRST AID

As Seizure Ends, Offer Help

Stay Calm
Don’t Hold Down

Cushion Head, Remove Glasses

Observe and Record What Happens

Don’t Put Anything in the Person’s Mouth, Turn on Their Side

Loosen Tight Clothing

Image adapted with permission from the Epilepsy Foundation of America

LEARN MORE AND GET A DOWNLOADABLE VERSION OF THIS ACTION PLAN AT:

childneurologyfoundation.org/sudep   dannydid.org   epilepsy.com/sudep-institute