SEIZURE ACTION PLAN (SAP)



END EPILEPSY

Name:	Birth Date:
	Phone:
Emergency Contact/Relationship	Phone:
Seizure Information	
Seizure Type How Long It Lasts How	Often What Happens
	- Comment
How to respond to a seizure (chec	ck all that apply) 🔽
☐ First aid – Stay. Safe. Side.	□ Notify emergency contact at
☐ Give rescue therapy according to SAP	□ Call 911 for transport to
☐ Notify emergency contact	□ Other
First aid for any seizure	When to call 911
	☐ Seizure with loss of consciousness longer than 5 minutes,
STAY calm, keep calm, begin timing seizure	not responding to rescue med if available
 Keep me SAFE – remove harmful objects, don't restrain, protect head 	Repeated seizures longer than 10 minutes, no recovery between them, not responding to rescue med if available
SIDE – turn on side if not awake, keep airway clear,	☐ Difficulty breathing after seizure
don't put objects in mouth	☐ Serious injury occurs or suspected, seizure in water
Stay until recovered from seizure	When to call your provider first
Swipe magnet for VNS Write down what happens	☐ Change in seizure type, number or pattern ☐ Person does not return to usual behavior (i.e., confused for a
Other	long period)
	☐ First time seizure that stops on its' own ☐ Other medical problems or pregnancy need to be checked
M/han recove theremy may ha	no o do de
When rescue therapy may be	needed.
WHEN AND WHAT TO DO	
Name of Med/Rx	
Name of Med/Rx	- · · · · · · · · · · · · · · · · · · ·
How to give	
If seizure (cluster, # or length)	
Name of Med/Rx	How much to give (dose)

Seizure Action Plan continued	
Care after seizure What type of help is needed? (describe)	
When is person able to resume usual activity?	
Special instructions	
First Responders:	
Emergency Department:	
Daily seizure medicine	
Medicine Name Total Daily Amount Tab/Liqu	id (time of each dose and how much)
Other information Triggers: Important Medical History Allergies	
Epilepsy Surgery (type, date, side effects) Device: UNS RNS DBS Date Implanted Diet Therapy Ketogenic Low Glycemic Modified A	
Health care contacts	Phone:
	Phone:
	Phone:
	Phone:
My signature	Date
Provider signature	Date Annual Date









Questionnaire for Parent of a Student with Seizures

Please complete all questions. This information is essential for the school nurse and school staff in determining your child's special needs and providing a positive and supportive learning environment. If you have any questions about how to complete this form, please contact your child's school nurse.

Contact Information					
Student's Name	All States (no. 1944) States and an experimental section of the control of the co		School Year	Date of Birth	The second section of the second section of the second section of the second section s
School			Grade	Classroom	enterentement et et et et en
Parent/Guardian	anti anti titi di Santa di Santa da Sa		Phone	Work	Cell
Parent/Guardian Email	teres and a second s	and a first many of the supplementation of th		en a delication and the second and t	en e
Other Emergency Contac	t	and the second s	Phone	Work	Cell
Child's Neurologist	en e		Phone	Location	
Child's Primary Care Doc	tor	Souther commencer and an arrangement of the commencer and arrangem	Phone	Location	The state of the s
Significant Medical Histor	y or Conditions			en e	
Seizure Information					
	diagnosed with se	izures or epilepsy	?		
2. Seizure type(s) Seizure Type	Length	Frequency		•	The second secon
			Description		
	v v v v v v v v v v v v v v v v v v v				
3. What might trigger a :	selzure in your chi				
4. Are there any warning If YES, please explain		changes before th	ne seizure occurs?	☐ YES ☐ NO	\$ () () () () () () () () () (
5. When was your child'	s last seizure?		4		
Has there been any re If YES, please explair	-	· ·	patterns?	YES 🗇 NO	
7. How does your child i					and the second
8. How do other illnesse					
Basic First Ald: Care	& Comfort			Basic !	Seizure First Aid
What basic first aid preschool?	rocedures should I	oe taken when you	ır child has a seizure i	Keep child Do not rest Do not put	safe rain anything in mouth nild until fully conscious
Will your child need to If YES, what process				 Protect hea 	d y open/watch breathing

11. Please describe what constitutes an emer consultation with treating physician and so consultation and treatment Info consultation with the property of the second physician and so consultation with treatment information and the physician and so consultation with the physician and so consultation with treatment physician and so consultation and treatment physician and so consultation with treatment physician and so consultation and treatment physician and so consultation with treatment physician and so consultation and treatment information and treatme	rmation Dosage Orescribed for your dministration Inside take during school istered in a specifor?	Frequency and Time of D our child? structions (timing* & method**) or tongue, rectally, etc. ool hours? otal way?	• Convionge • Stude • Stude • Stude • Stude • Stude • Stude	hat to Do After Administration
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General health Physical functioning	ideration or prec	cautions that should be taken:	· · · · · · · · · · · · · · · · · · ·	to an angular contraction of the second seco
		☐ Physical education (gym	/sports)	
J Learning	~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~	☐ Recess		
	·	☐ Field trips		
) Daligaini		☐ Bus transportation		
Mood/coping	tan-in percental security secu	Other		
Gaporal Communication Inc.				
General Communication Issues	and the second s	e provinci signer successi se e e e e e e e e e e e e e e e e	and the state of t	de transferior and the second and th
23. What is the best way for us to communicate				
24. Can this information be shared with classro	om teacher(s) an		ersonnel?	☐ YES ☐ NO
The second secon				Data
		TO THE TRANSPORT OF THE PARTY O	freezentini e i component	Dates
Parent/Guardian Signature				Dates Updated