SEIZURE ACTION PLAN (SAP)

How to give __





Name:			Birth Date:		
Address:			Phone:		
Emergency Contact/Relationshi	ip				
Seizure Information	on				
Seizure Type How Long It Lasts I		How Often	How Often What Happens		
How to respond First aid – Stay. Safe. Sid Give rescue therapy according	e.	□ No	hat apply) otify emergency contact at		
□ Notify emergency contact			Other		
First aid for any seizure STAY calm, keep calm, begin timing seizure Keep me SAFE – remove harmful objects, don't restrain, protect head SIDE – turn on side if not awake, keep airway clear, don't put objects in mouth STAY until recovered from 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 med if available Repeated seizures longer than 10 minutes, no recovery between them, not responding to rescue med 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 AND WHAT TO DO If seizure (cluster, # or lengt					
Name of Med/Rx			How much to give (dose)		
riow to give					
Name of Med/Rx					
now to give					
If seizure (cluster, # or lengt			How much to give (dose)		

Care after seiz							
What type of help is needed? (describe)							
Special instruc							
•							
I list Responders							
Emergency Departmen	t:						
Daily seizure n	nedicine						
Medicine Name	Total Daily Amount	Amount of Tab/Liquid	How Taken (time of each dose and how much)				
Other informat	ion						
Triggers:							
Important Medical History	·						
Allergies							
Epilepsy Surgery (type, da	ate, side effects)						
Device: ☐ VNS ☐ RNS	S □ DBS Date Implant	ed					
Diet Therapy ☐ Ketogen	nic \square Low Glycemic \square	Modified Atkins	her (describe)				
Special Instructions:							
Health care contacts	;						
Epilepsy Provider:			Phone:				
Primary Care:			Phone:				
Preferred Hospital:			Phone:				
Pharmacy:			Phone:				
My signature			Date				
Provider signature			Date				



