SEIZURE ACTION PLAN FOR

_____ (INSERT NAME HERE)

Attach Photo

ABOUT

Name _____ Date of Birth _____

Doctor's Name (Primary physician to call when seizure occurs) _____ Phone _____

Emergency Contact Name _____ Phone _____

Emergency Contact Name _____ Phone _____

Seizure Type(s) / Name(s): _____

What Happens: _____

How Long It Lasts: _____

How Often: _____

Seizure Triggers*:

**If multiple seizure types, consider talking to your school about additional details they may need to know.*

☐ Missed Medicine ☐ Emotional Stress ☐ Alcohol / Drugs ☐ Menstrual Cycle ☐ Missing meals

☐ Lack of Sleep ☐ Physical Stress ☐ Flashing Lights ☐ Illness with high fever

☐ Response to specific food, or excess caffeine Specify: _____ ☐ Other Specify: _____

DANGER – GET HELP NOW

☐ 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

Other reasons to call 911: _____

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:

☐ Preferred hospital: _____

SEIZURE ACTION PLAN

DAILY TREATMENT PLAN

Seizure Medicine(s) *(Ensure school has full prescription instructions.)*

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

CAUTION–STEP UP TREATMENT

Some symptoms can signal that a seizure may be coming on. _____ has the following symptoms as warning sign for an impending seizure and may need additional treatment.

☐ 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, safe position): _____

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

LEARN MORE AT:

Child Neurology Foundation — Creating a Community of Support
childneurologyfoundation.org/sudep

Danny Did® Foundation
dannydid.org

Epilepsy Foundation SUDEP Institute
epilepsy.com/sudep-institute

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