

## Acute Seizure Action Plan

Name: _____	Birth date: _____	Today's date: _____
Care partner phone numbers: _____	Provider name/facility: _____	Provider phone numbers: _____



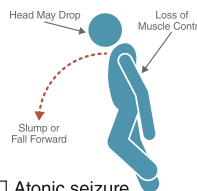
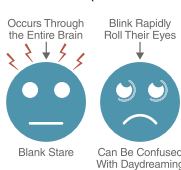
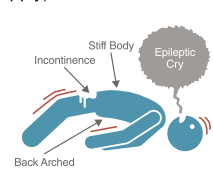
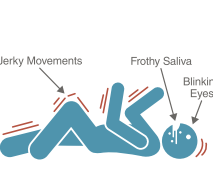

### Usual Seizure Pattern

**Triggers:** \_\_\_\_\_

**Pattern of seizures:** \_\_\_\_\_

**Allergies:** \_\_\_\_\_

**What the seizures normally look like (Check all that apply)**

 <p>Head May Drop Loss of Muscle Control Slump or Fall Forward</p>	 <p>Occurs Through the Entire Brain Blink Rapidly Roll Their Eyes Blank Stare Can Be Confused With Daydreaming</p>	 <p>Incontinence Stiff Body Epileptic Cry Back Arched</p>	 <p>Jerky Movements Frothy Saliva Blinking Eyes</p>	 <p>Occurs in Specific Lobe of the Brain Blank Stare</p>
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Describe: \_\_\_\_\_





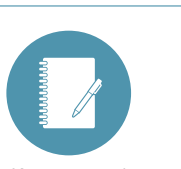
Atonic seizure (also called drop)    
  Absence seizure (also called petit mal)    
  Tonic seizure    
  Clonic seizure    
  Focal impaired awareness seizure (also called complex partial)

NOTES: \_\_\_\_\_

### Care




**Standard Care Needed**

If this happens, \_\_\_\_\_ provide standard care


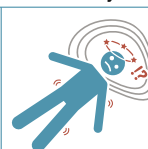


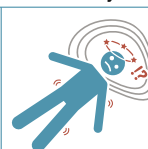




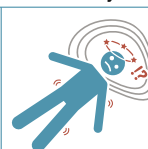

 <p>Time the seizure</p> <p>NOTES: _____</p>	 <p>Keep person safe</p> <p>NOTES: _____</p>	 <p>Don't restrict</p> <p>NOTES: _____</p>	 <p>Stay with person</p> <p>NOTES: _____</p>	 <p>Keep a record</p> <p>NOTES: _____</p>
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**Provide Rescue Treatment**

If this happens, \_\_\_\_\_ provide standard care (above) **and** rescue treatment

 <p><input type="checkbox"/> Rectum</p>	 <p><input type="checkbox"/> Nose</p>	 <p><input type="checkbox"/> Mouth</p>	<p><b>Specific instructions:</b> _____</p> <p><input type="checkbox"/> Other: _____</p>
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**Call for Emergency Help**

<p style="text-align: center;"><b>If any of these happen,</b></p> <table style="width: 100%;"> <tr> <td style="width: 33%; text-align: center;">  <p><input type="checkbox"/> Seizure longer than _____ minutes</p> </td> <td style="width: 33%; text-align: center;">  <p><input type="checkbox"/> Unusual seizure</p> </td> <td style="width: 33%; text-align: center;">  <p><input type="checkbox"/> Injury/Blue lips</p> </td> </tr> </table> <p><input type="checkbox"/> Other: _____</p> <p>NOTES: _____</p>	 <p><input type="checkbox"/> Seizure longer than _____ minutes</p>	 <p><input type="checkbox"/> Unusual seizure</p>	 <p><input type="checkbox"/> Injury/Blue lips</p>	<p style="text-align: center;"><b>Get help now</b></p> <div style="text-align: center;">   </div> <p><b>Call Healthcare Provider if:</b> _____</p> <p><b>Call for Emergency Help if:</b> _____</p> <p>NOTES: _____</p>
 <p><input type="checkbox"/> Seizure longer than _____ minutes</p>	 <p><input type="checkbox"/> Unusual seizure</p>	 <p><input type="checkbox"/> Injury/Blue lips</p>		

**Healthcare Provider Authorization**

Signature: \_\_\_\_\_ Provider Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_ For use from: \_\_\_\_\_ to: \_\_\_\_\_

Seizure Details		
Seizure Type	Length of Seizure	Frequency
<b>Seizure Warning(s):</b>		
<b>Response After Seizure (Postictal):</b>		
Medication Management		
Medication Name	Dosage and Time of Day Given	Side Effects/Special Instructions
Emergency Medication		
Medication Name	Dosage	Side Effects/Special Instructions
Vagus Nerve Stimulator		
Does the student have VNS? Yes _____ No _____	If yes, provide magnet instructions:	
Diet Therapy		
Is the student on any diet therapy for epilepsy? Yes _____ No _____	If yes, provide instructions:	