

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><input type="checkbox"/> Atonic seizure (also called drop)</p>	<p>Occurs Through the Entire Brain Blank Stare</p> <p><input type="checkbox"/> Absence seizure (also called petit mal)</p>	<p>Blink Rapidly Roll Their Eyes Can Be Confused With Daydreaming</p> <p><input type="checkbox"/> Tonic seizure</p>	<p>Stiff Body Incontinence Epileptic Cry</p> <p><input type="checkbox"/> Clonic seizure</p>	<p>Occurs in Specific Lobe of the Brain Blank Stare</p> <p><input type="checkbox"/> Focal impaired awareness seizure (also called complex partial)</p>	<p>Describe: _____</p> <p>_____</p> <p>_____</p> <p>_____</p>
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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>Specific instructions: _____</p> <p>_____</p> <p><input type="checkbox"/> Other: _____</p>
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Call for Emergency Help

If any of these happen,				Get help now
<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><input type="checkbox"/> Other: _____</p> <p>_____</p> <p>_____</p>	<p>Call Healthcare Provider if: _____</p> <p>Call for Emergency Help if: _____</p>
NOTES: _____				NOTES: _____

Healthcare Provider Authorization

Signature: _____ Provider Printed Name: _____ Date: _____ For use from: _____ to: _____