Acute Seizure Action Plan

Name: _____ Birth date: _____ Today's date: _____

Care partner phone numbers: _____

Provider name/facility: _____

Provider phone numbers: _____

Usual Seizure Pattern

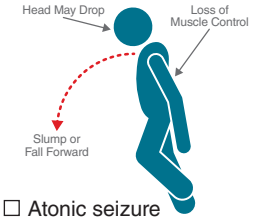
Triggers: _____

Pattern of seizures: _____

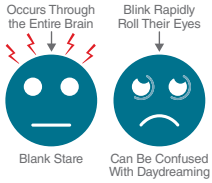
Allergies: _____

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

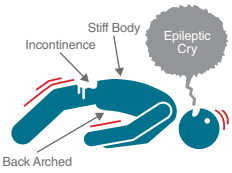
Describe: _____



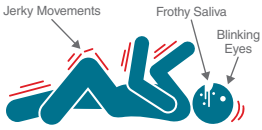
☐ Atonic seizure (also called drop)



☐ 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**

Time the seizure

NOTES: _____

Keep person safe

NOTES: _____

Don't restrict

NOTES: _____

Stay with person

NOTES: _____

Keep a record

NOTES: _____

Provide Rescue Treatment

If this happens, _____

_____ **provide standard care** (above) ***and*** **rescue treatment**

☐ Rectum

☐ Nose

☐ Mouth

Specific instructions: _____

☐ Other: _____

Call for Emergency Help

If any of these happen,

☐ **Seizure longer than ____ minutes**

☐ **Unusual seizure**

☐ **Injury/Blue lips**

☐ **Other:** _____

NOTES: _____

Get help now

Call Healthcare Provider if: _____

Call for Emergency Help if: _____

NOTES: _____

Healthcare Provider Authorization

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