SEIZURE ACTION PLAN (SAP)

CALHOUN COUNTY School Wellness Program

EPILEPSY FOUNDATION | END EPILEPSY

Name: _____ Birth Date: _____

Address: _____ Phone: _____

Emergency Contact/Relationship _____ Phone: _____

Seizure Information

Seizure Type	How Long It Lasts	How Often	What Happens

How to respond to a seizure (check all that apply) ☑

- ☐ First aid – **Stay. Safe. Side.**
- ☐ Give rescue therapy according to SAP
- ☐ Notify emergency contact
- ☐ Notify emergency contact at _____
- ☐ Call 911 for transport to _____
- ☐ 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 **rescue therapy** may be needed:

WHEN AND WHAT TO DO

If seizure (cluster, # or length) _____

Name of Med/Rx _____ How much to give (dose) _____

How to give _____

If seizure (cluster, # or length) _____

Name of Med/Rx _____ How much to give (dose) _____

How to give _____

If seizure (cluster, # or length) _____

Name of Med/Rx _____ How much to give (dose) _____

How to give _____

Care after seizure

What type of help is needed? (describe) _____

When is person able to resume usual activity? _____

Special instructions

First Responders: _____

_____

Emergency Department: _____

_____

Daily seizure medicine

Medicine Name	Total Daily Amount	Amount of Tab/Liquid	How Taken (time of each dose and how much)

Other information

Triggers: _____

Important Medical History _____

Allergies _____

Epilepsy Surgery (type, date, side effects) _____

Device: ☐ VNS ☐ RNS ☐ DBS Date Implanted _____

Diet Therapy ☐ Ketogenic ☐ Low Glycemic ☐ Modified Atkins ☐ Other (describe) _____

Special Instructions: _____

_____

Health care contacts

Epilepsy Provider: _____ Phone: _____

Primary Care: _____ Phone: _____

Preferred Hospital: _____ Phone: _____

Pharmacy: _____ Phone: _____

My signature _____ Date _____

Provider signature _____ Date _____

Epilepsy.com

Revised 01/2020 130SRP/PAB1216

CALHOUN COUNTY School Wellness Program

EPILEPSY FOUNDATION

END EPILEPSY

1. As parent/guardian of _____, I give permission for this plan to be available for use in my child's school, and for the nurse consultant to contact the above named physician by phone, fax, or in writing when necessary to complete this plan.
2. It is understood by parents and physicians that this plan may be carried out by school personnel other than the school nurse. The school's Registered Nurse is responsible for delegation of this plan to unlicensed school personnel when appropriate.
3. This plan will be reviewed annually and/or whenever the health status or medications change and it is the responsibility of the parent to notify the school nurse of these changes.

Physician Signature:		Date:
Parent Signature:		Date:
School Nurse Signature:		Date:
Student Signature:		Date: