



Seizure Response Plan

(LAST NAME) (FIRST) (MIDDLE) (DOB) (ID #)

(HOME ADDRESS) (ZIP CODE) (TELEPHONE)

(PARENT'S/ GUARDIAN'S NAME) (SCHOOL)

Seizure Information

Seizure Type/Nickname	What Happens?	How Long It Lasts?	How Often?

Seizure Triggers:

Daily Seizure Medications

Medication Name	Total Daily Amount	Amount Tab/Liquid	How taken?

Other Seizure Treatments

Device Type: _____ Model: _____ Serial# _____ Date Implanted _____

Dietary Therapy: _____ Date Begun: _____

Special Instructions _____

Other Therapy _____



Seizure First Aid:

- Keep calm, provide reassurance, remove bystanders
- Keep airway clear, turn on side if possible, nothing in mouth
- Keep safe, remove objects, do not restrain
- Time, observe, record what happens
- Stay with person until recovered from seizure
- Other care needed:

Call 911 if...

- Generalized seizure longer than 5 minutes
- Two or more seizures without recovering between seizures
- "As needed" treatments don't work
- Injury occurs or is suspected, or seizure occurs in water
- Breathing, heart rate or behavior doesn't return to normal
- Unexplained fever or pain, hours or few days after a seizure
- Other care needed

When Seizures Require Additional Help

Type of Emergency (long, clusters, or repeated events)	Description	What to Do?

"As Needed" Treatments (VNS magnet, medicines)

Name	Amount to Give	When to Give?	How to give?

Health Care Contact

Epilepsy Doctor: _____ Phone _____

Nurse/Other Health Care Provider: _____ Phone: _____

Preferred Hospital: _____ Phone: _____

Primary Care: _____ Phone: _____

Pharmacy: _____ Phone: _____

Special Instructions _____

Parent Signature _____ Date _____

Provider Signature _____ Date _____