MY SEIZURE PLAN

Name: _____ **Birth Date**: _____

Address: _____ **Phone**: _____

1st Emergency Contact: _____ **Relation**: _____

Phone(s): _____ **Email**: _____

2nd Emergency Contact: _____ **Relation**: _____

Phone(s): _____ **Email**: _____

SEIZURE INFORMATION

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

TRIGGERS

_____

_____

DAILY SEIZURE MEDICINE

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

OTHER SEIZURE TREATMENTS

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

Diatery Therapy:_____ Date Begun:_____

Special Instructions:_____

Other Therapy:_____

MY SEIZURE PLAN

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:_____

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

CALL 911 OR SEEK EMERGENCY MEDICAL ATTENTION 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:_____

HEALTH CARE CONTACTS

Epilepsy Doctor:_____ Phone: _____
Nurse/Other Health Care Provider:_____ Phone: _____
Preferred Hospital:_____ Phone: _____
PCP or Other Doctor:_____ Phone: _____
Pharmacy:_____ Phone: _____

SPECIAL INSTRUCTIONS: _____

_____

My signature _____ **Provider signature**_____ **Date** _____

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