

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 |
|-----------------------|--------------|-------------------|-----------|
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TRIGGERS

DAILY SEIZURE MEDICINE

| Medicine Name | Total Daily Amount | Amount of Tab/Liquid | How Taken (time of each dose and how much) |
|---------------|--------------------|----------------------|--|
| | | | |
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OTHER SEIZURE TREATMENTS

Device Type: _____ Model: _____ Serial#: _____ Date Implanted: _____
Dietary Therapy: _____ Date Begun: _____
Special Instructions: _____
Other Therapy: _____

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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 |
|--|-------------|------------|
| | | |
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| | | |

“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** _____