



My Seizure Response Plan

Name: _____ Birth Date: _____
 Address: _____ Phone: _____
 1st Emergency Contact /Relation: _____ Phone: _____
 2nd Emergency Contact / Relation: _____ Phone: _____

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: _____

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 |
|--|-------------|------------|
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"As Needed" Treatments (VNS magnet, medicines)

| Name | Amount to Give | When to Give | How to Give |
|------|----------------|--------------|-------------|
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| | | | |
| | | | |

Health Care Contact

Epilepsy Doctor: _____ Phone: _____

Nurse/Other Health Care Provider: _____ Phone: _____

Preferred Hospital: _____ Phone: _____

Primary Care: _____ Phone: _____

Pharmacy: _____ Phone: _____

Special Instructions: _____

My signature _____ *Date* _____

Provider signature _____ *Date* _____

