My Seizure Response Plan

EPILEPSY FOUNDATION

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

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 _____

Dietary Therapy: _____ Date Begun: _____

Special Instructions: _____

_____

Other Therapy: _____

_____

continued on back

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: _____

_____

My signature _____ Date _____

Provider signature _____ Date _____

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