



Seizure Action Plan



A resource from Ericscorner.org

Name: _____ Date of Birth: _____

Emergency contact name: _____ Phone # _____

Treating Physician name: _____ phone # _____

- Diagnosis of Epilepsy
- Diagnosis of seizures

Most common type of seizures experienced(begin with most often experienced)

| Seizure Type | Average length of seizures (ex. 45 seconds) | Frequency (ex. Twice per month) | Description (type of movement of body, eyes or mouth etc.) |
|--------------|--|------------------------------------|---|
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| | | | |

Medications/ Prescriptions

| Name of prescription | Dose amount & time of day to be taken |
|----------------------|---------------------------------------|
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| | |
| | |

Emergency Medications / Prescriptions

| Name of Prescription | Dose | Route of Administration |
|----------------------|------|-------------------------|
| | | |
| | | |

- I have a VNS Serial # for Lead _____ # for Generator _____
- I have DBS - _____
- I have had brain surgery _____

Known Seizure Triggers or warning signs:

Describe how your typical seizure looks or plays out:

Requested response to seizure / basic care:

(Include personal desire for response to seizure care, ie. Protect head, Time seizure length etc. also instructions for VNS magnet or emergency medications if applicable)

A seizure emergency is defined as the following for me:

Typical Post seizure behavior:

Specific post seizure protocol: _____

Please activate 911 if / when: _____

Please call emergency contact if / when: _____

Please call my doctor if / when: _____

- Thank you for your assistance, please stay with me until I am alert.
- Thank you for your assistance please leave me a note with details about the event.
- Thank you for your assistance please _____