MY SEIZURE PLAN

Epilepsy Foundation Eastern PA
919 Walnut Street, Suite 700
Philadelphia, PA 19107

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

____

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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:____

EPILEPSY FOUNDATION
Eastern Pennsylvania

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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

"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** ______________