

Acute Seizure Action Plan

Student Name: _____	Birth date: _____	Today's date: _____
Family phone numbers: _____	Provider name/facility: _____	
	Provider phone numbers: _____	




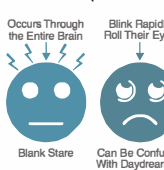
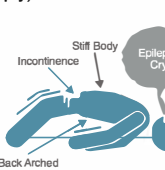
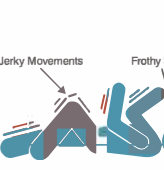
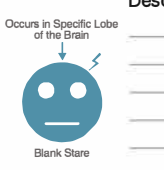
Usual Seizure Pattern

Triggers: _____

Pattern of seizures: _____

Allergies: _____

What the seizures normally look like (Check all that apply)

 <p>Head May Drop Loss of Muscle Control Slump or Fall Forward</p>	 <p>Occurs Through the Entire Brain Blink Rapidly Foil Their Eyes Blank Stare Can Be Confused With Daydreaming</p>	 <p>Incontinence Stiff Body Epileptic Cry Back Arched</p>	 <p>Jerky Movements Frothy Saliva Blinking Eyes</p>	 <p>Occurs in Specific Lobe of the Brain Blank Stare</p>
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Describe: _____






Atonic seizure (also called drop)
 Absence seizure (also called petit mal)
 Tonic seizure
 Clonic seizure
 Focal impaired awareness seizure (also called complex partial)

NOTES: _____

Care




Standard Care Needed

If this happens, _____ provide standard care



 <p>Time the seizure</p> <p>NOTES: _____</p>	 <p>Keep Person Safe</p> <p>NOTES: _____</p>	 <p>Don't restrict</p> <p>NOTES: _____</p>	 <p>Stay with person</p> <p>NOTES: _____</p>	 <p>Keep a record</p> <p>NOTES: _____</p>
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Provide Rescue Treatment

If this happens, _____ provide standard care (above) **and** rescue treatment

 <p><input type="checkbox"/> Rectum</p>	 <p><input type="checkbox"/> Nose</p>	 <p><input type="checkbox"/> Mouth</p>	Medication Order: _____ <input type="checkbox"/> Other: _____
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Call for Emergency Help

If any of these happen,	Get help now				
<input type="checkbox"/> Seizure longer than _____ minutes	<input type="checkbox"/> Unusual seizure	<input type="checkbox"/> Injury/Blue lips	<input type="checkbox"/> Other: _____	 	Call Healthcare Provider if: _____ Call for Emergency Help if: _____
NOTES: _____				NOTES: _____	

Healthcare Provider Authorization

Signature: _____ Provider Printed Name: _____ Date: _____ For use from: _____ to: _____