SEIZURE ACTION PLAN (SAP)

Student's Name: _____ DOB: _____

School Year: _____ Grade: _____

Student's Address: _____ Phone: _____

Parent/Guardian: _____ Phone: _____

Parent/Guardian: _____ Phone: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Health care contacts

Epilepsy Provider: _____ Phone: _____

Primary Care: _____ Phone: _____

Preferred Hospital: _____ Phone: _____

Pharmacy: _____ Phone: _____

Seizure Information

Seizure Type	How Long It Lasts	How Often	What Happens

Protocol for seizure during school ☑ check all that apply

- ☐ First aid – **Stay. Safe. Side.**
- ☐ Give rescue therapy according to SAP
- ☐ Notify parent/emergency contact
- ☐ Contact school nurse at _____
- ☐ Call 911 for transport to _____
- ☐ Other: _____

First aid for any seizure

- ☐ **STAY** calm, keep calm, **begin timing seizure**
- ☐ Keep student **SAFE** – remove harmful objects, don't restrain, protect head
- ☐ **SIDE** – turn student on their side if not awake, keep airway clear, and don't put objects in mouth
- ☐ **STAY** until recovered from seizure
- ☐ Swipe VNS magnet (if applicable)
- ☐ Write down what happens
- ☐ Other: _____

When to call 911 (check all that apply)

- ☐ Seizure with loss of consciousness longer than 5 minutes, not responding to rescue medication (if applicable for student)
- ☐ Repeated seizures longer than 10 minutes, no recovery in between seizures, not responding to rescue medication (if applicable for student)
- ☐ Difficulty breathing after seizure
- ☐ Seizure injury occurs or is suspected, seizure in water

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When rescue therapy may be needed

WHEN AND WHAT TO DO

If seizure (cluster, # or length): _____

Name of Med/Rx: _____ How much to give (dose): _____

How to give: _____

Storage location: _____

If seizure (cluster, # or length): _____

Name of Med/Rx: _____ How much to give (dose): _____

How to give: _____

Storage location: _____

If seizure (cluster, # or length): _____

Name of Med/Rx: _____ How much to give (dose): _____

How to give: _____

Storage location: _____

Care after a seizure

What type of help is needed? (describe): _____

When is student able to resume usual activity? _____

Special Instructions

First Responders: _____

Emergency Department: _____

Daily Seizure Medication

Medicine Name	Total Daily Amount	Amount of Tab/Liquid	How Taken (time of each dose and how much)

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Other information

Seizure triggers: _____

Important Medical Information: _____

Allergies: _____

Epilepsy Surgery (type, date, side effects): _____

Device: ☐ VNS ☐ RNS ☐ DBS Date Implanted: _____

Diet Therapy: ☐ Ketogenic ☐ Low Glycemic ☐ Modified Atkins ☐ Other (describe): _____

Special Instructions (including precautions/restrictions regarding school activities, sports, trips, etc.): _____

Signatures

Parent/Guardian Signature: _____ **Date:** _____

Provider Signature: _____ **Date:** _____

Parent/Guardian Acknowledgement

Individuals with Disabilities Education Act (IDEA) & Section 504

☐ I was notified by my local educational agency that my child may qualify for services or accommodations pursuant to Section 504 of the federal Rehabilitation Act of 1973 or an individualized education program.

☐ I understand that my local educational agency shall assist me in exploring my child's options for Section 504 of the federal Rehabilitation Act of 1973 or an individualized education program.

☐ I understand it is my right to request a plan pursuant to Section 504 of the federal Rehabilitation Act of 1973 (29 U.S.C. Sec. 794) or an individualized education program at any time.

☐ I was notified by my local educational agency of my child's right to be assessed for services and accommodations guaranteed under Section 504 and the federal Individuals with Disabilities Education Act if there are not volunteers at my child's school to be trained to recognize and respond to seizures, including training to administer emergency anti-seizure medication to a pupil diagnosed with seizures, a seizure disorder, or epilepsy if the pupil is suffering from a seizure.

Nonmedical Professional Response

☐ I acknowledge that my child's seizure may be responded to, including with the administration of emergency anti-seizure medication prescribed to my child, by a nonmedical professional who has received training.

Parent/Guardian Signature: _____ **Date:** _____

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