SEIZURE ACTION PLAN (SAP)

EPILEPSY FOUNDATION

Name: _____ Birth Date: _____

Address: _____ Phone: _____

Emergency Contact/Relationship: _____ Phone: _____

Seizure Information

Seizure Type	How Long It Lasts	How Often	What Happens

How to respond to a seizure (check all that apply)

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

First Aid for any seizure

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

  _____
- ☐ Other

  _____

When to call 911

- ☐ Seizure with loss of consciousness longer than 5 minutes, not responding to rescue med if available
- ☐ Repeated seizures longer than 10 minutes, no recovery between them, not responding to rescue med if available
- ☐ Difficulty breathing after seizure
- ☐ Serious injury occurs or suspected, seizure in water

When to call your provider first

- ☐ Change in seizure type, number or pattern
- ☐ Person does not return to usual behavior (i.e., confused for a long period)
- ☐ First time seizure that stops on its' own
- ☐ Other medical problems or pregnancy need to be checked

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 _____

If seizure (cluster, # or length) _____

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

How to give _____

If seizure (cluster, # or length) _____

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

How to give _____

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Care after seizure

What type of help is needed? (describe) _____

When is person able to resume usual activity? _____

Special instructions

First Responders: _____

_____

Emergency Department: _____

_____

Daily seizure medicine

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

Other information

Triggers: _____

Important Medical History: _____

Allergies: _____

Epilepsy Surgery (type, date, side effects) _____

Device: ☐ VNS ☐ RNS ☐ DBS Date Implanted _____

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

Special Instructions: _____

_____

Health care contacts

Epilepsy Provider: _____ Phone: _____

Primary Care: _____ Phone: _____

Preferred Hospital: _____ Phone: _____

Pharmacy: _____ Phone: _____

My signature: _____ Date _____

Provider Signature: _____ Date: _____

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'iolani School Student Self Medication Administration Form for School Year _____

PHYSICIAN ORDER AND PARENT/GUARDIAN AUTHORIZATION FOR SELF MEDICATION ADMINISTRATION

(Please complete one form for each medication.)

Student's Name: _____DOB: _____

Allergies: _____

Medication: _____Dosage: _____Route: _____

Reason for medication or diagnosis: _____

Self-administration of medication by student : Students who require emergent medication for the treatment of asthma, anaphylaxis, seizures, or diabetes will be allowed to carry and self administer medications with completed consent on file in Magnus Health.

This **Student Self Medication Administration** form is required and must be signed by the student's physician/healthcare provider and parent verifying the necessity and student's ability to self administer the medication appropriately. Please be sure to complete ALL of the information on this authorization form before returning it to school. This authorization is valid for one school year and must be renewed at the beginning of each new school year.

Students are responsible for bringing these medications on any off campus excursions or school sponsored trips.

PHYSICIAN'S ORDER

1. I have examined this student for (diagnosis): _____and have determined that he/she requires access to personal emergency medication during school hours.

2. Name of Medication:_____

3. Dosage & Route: _____

4. I believe this student is able to carry and administer his or her own medication (excluding controlled substances) at the appropriate time and in the appropriate way.

Please check: ____YES _____NO *I understand that self-administered medication is not provided by or monitored by the school staff.

Physician's Signature: _____Date: _____/ _____/ _____

Printed Name: _____Phone: _____

PARENT/GUARDIAN STATEMENT

I/We, the undersigned Parent(s) Guardian(s) of _____give consent for my/our child to self-administer the above medication. I/We hereby agree to release and hold the school staff free and harmless for any claims, demands, or suits for damages from any injury or complication that may result from such treatment. I have read this consent and understand all its terms. I sign it voluntarily and with full knowledge of its significance. I understand that self-administered medication is not provided by or monitored by 'Iolani School staff. I will also reinforce with my child, that they are not to share medications with others. * Parent / Student are responsible to have the medication available at school.

X _____ ____/ ____/ ____

(Parent/Guardian Signature) Date

Home Phone: _____Work: _____Cell: _____

X _____ ____/ ____/ ____

(Parent/Guardian Signature) Date

Home Phone: _____Work: _____Cell: _____