Mumford ISD
Seizure Action Plan (SAP)

Name: _____ Birthdate: _____

Parent/Guardian: _____ Phone: _____

I agree with the recommendations below from my child's physician and give permission for my child to receive medication(s) as directed. By signing this, I give permission for my child's physician to share written and or verbal information with the school nurse for the entire school year.

Parent/Guardian Signature: _____ Date: _____

BELOW TO BE FILLED OUT BY PHYSICIAN

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)

☐ Notify Emergency Contact: _____@ _____

☐ Other: _____

☐ Give Rescue Therapy according to SAP

☐ Call 911 for transport to_____

First Aid for any Seizure

☐ **Stay**: calm, begin timing seizure

☐ **Side**: turn on side if not awake, keep airway clear, do not put objects in mouth

☐ Swipe magnet for VNS

☐ Administer Emergency medication as indicated below

☐ **Safe**: remove harmful objects, do not restrain, protect head

☐ **Stay**: until recovered from seizure

☐ Write Down what happens: _____

☐Other: _____

When to call 911:

☐ Seizure with loss of consciousness longer than 5 minutes

☐ Repeated Seizures longer than 10 minutes, no recovery between them, not responding to rescue medication available

☐ Difficulty breathing after Seizure

☐ Serious injury occurs or suspected, seizure in water

When to call you 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

Rescue Medication/Therapy

Medication	Dosage	Route	When to give

Daily Seizure Medication:

Medication	Dosage	Route	Time give

Other Information:

Triggers: _____

Important Medical History: _____

Allergies: _____

Epilepsy Surgery: (Type, Date, Side Effects): _____

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

Diet Therapy: _____

Special Instructions: _____

Contacts:

Call 911

Epilepsy Provider: _____ Phone: _____

Primary Care Provider: _____ Phone: _____

Parent/Guardian: _____ Phone: _____

Parent/Guardian: _____ Phone: _____

Physician Signature: _____ Date: _____