



CENTER FOR SPECIAL SERVICES

1606 Old Orchard Street, White Plains, New York 10604

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SEIZURE ACTION PLAN (SAP)

Student Information	
Student's Name:	Student's D.O.B
Address:	
Emergency Contact Name/Relationship:	Contact Information:

Seizure Information

Seizure Type	How Long Does It Last	How Often	What Happens

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

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

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

Care After Seizure

What type of help is needed? (describe) _____

When is the person able to resume their 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:

Parent/Guardian Signature:	Date:
Physician Signature:	Date:
Stamp/Address:	
Phone:	