ADULT Seizure Action Plan & Patient Questionnaire

THIS INDIVIDUAL IS BEING TREATED FOR A SEIZURE DISORDER. INFORMATION BELOW SHOULD ASSIST YOU IF A SEIZURE OCCURS.

Name: _____ Date of Birth: _____

Emergency Contact: _____ Phone: _____ Cell: _____

Treating Physician: _____ Phone: _____

Significant medical history: _____

SEIZURE INFORMATION:

Seizure Type	*Length*	*Frequency*	*Description*

Seizure triggers or warning signs: _____

Post seizure behavior: _____

BASIC FIRST AID: CARE & COMFORT:

Please describe basic first aid procedures: _____

_____

Does person need to leave the room/area after a seizure? YES NO

If YES, describe process for returning: _____

_____

Basic seizure first aid:
- Stay calm & track time
- Keep person safe
- Do not restrain
- Do not put anything in mouth
- Stay with person until fully conscious
- Record seizure in log

For tonic-clonic (grand mal) seizure:
- Protect head
- Keep airway open/watch breathing, color
- Turn person on side

EMERGENCY RESPONSE:

A "seizure emergency" for this person is defined as: _____

_____

A seizure is considered an emergency when:
- A convulsive (tonic-clonic) seizure lasts longer than 5 minutes
- There are repeated seizures without regaining consciousness
- It's a first-time seizure
- The person is injured or has diabetes
- The person has breathing difficulties
- The seizure is in water

Seizure Emergency Protocol: *(Check all that apply and clarify below*

☐ Call 911 for transport to _____
- ☐ Notify parent or emergency contact
- ☐ Notify doctor
- ☐ Administer emergency medications as indicated below
- ☐ Other _____

TREATMENT PROTOCOL: (include daily and emergency medications)

Emergency Med? ✓	*Medication*	*Dosage & Time of Day Given*	*Route of Administration*	*Common Side Effects & Special Instructions*

Does person have a **Vagus Nerve Stimulator (VNS)**? YES NO

If YES, describe magnet protocol _____

SPECIAL CONSIDERATIONS & SAFETY PRECAUTIONS: *(regarding activities, sports, travel, etc.)*

Physician Signature: _____ **Date:** _____

Individual Signature: _____ **Date:** _____

Parent/Guardian Signature (if minor): _____ **Date:** _____

EPILEPSY FOUNDATION Minnesota

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SEIZURE INFORMATION:

1. When was your epilepsy diagnosed?_____
2. Will you need to leave the area after a seizure? YES NO
   If YES, describe best process for returning:_____
3. How often do you have seizures?_____
4. When was the last seizure?_____
5. Has there been any recent change in your seizure patterns? YES NO
   If YES, please explain:_____
6. Does illness or stress affect your seizure control?_____
7. What medication(s) will you need to take during work/program?_____
8. Should any of these medications be administered in a special way? YES NO
   If YES, please explain:_____
9. Should any particular reaction be watched for? YES NO
   If YES, please explain:_____
10. What should be done if you miss a dose?_____
11. Should there be backup medication available on site for missed dose? YES NO
12. Should anyone be notified before backup medication is given for a missed dose? YES NO
    If so, who _____ Contact Number _____

SPECIAL CONSIDERATIONS & PRECAUTIONS

Check any special considerations related to your epilepsy while at work/program. *(Check appropriate boxes and describe the impact of your child's seizures or treatment regimen)*

- ❑ General health:
- ❑ Physical functioning:
- ❑ Learning:
- ❑ Behavior:
- ❑ Mood/coping:
- ❑ Other:_____
- ❑ Recreation /sports:
- ❑ Transportation:

GENERAL COMMUNICATION ISSUES

What is the best way for us to communicate with your emergency contact?:_____

Do you give permission to contact your physician? YES NO

Can this information be shared with other appropriate work/program personnel? YES NO

If so, who _____

Patient Signature:_____Date:_____ Dates Updated _____, _____

Physician Signature:_____Date:_____

Visit EFMN.ORG for additional resources.