Seizure Action Plan
Supplemental Form

Participant Name: ___________________________________________ Date: __________________

**Basic Information:** Please provide background information on the nature of the seizures (i.e. type, triggers, length, etc.)

<table>
<thead>
<tr>
<th>Seizure Type</th>
<th>Length</th>
<th>Frequency</th>
<th>Description</th>
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1. Are there triggers/warning signs? ______________________________________________

2. How will the participant respond/behave once the seizure is over? ____________________

**History & Management of Seizures:**

1. When was the participant’s last seizure? ____________________________________________

2. Has the participant been hospitalized for continuous seizures? ☐ yes ☐ no

3. Does the participant have a Vagus Nerve Stimulator (VNS)? ☐ yes ☐ no
   
   B. Describe use of the magnet: ____________________________________________________

4. Does the participant take medication(s) for their seizures? ☐ yes ☐ no
   
   A. Will this medication need to be administered at the Respite event? ☐ yes ☐ no

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dose</th>
<th>Route of administration (i.e: oral, rectal, etc.)</th>
<th>The medication is for emergencies only</th>
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<tr>
<td></td>
<td></td>
<td></td>
<td>☐ yes ☐ no</td>
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* If medication (including emergency meds) is needed during the Respite event, parents/caregivers must complete a medication administration form which will be provided at sign-in to each event. Medication must be in original container.

**Seizure Emergency Protocol:** please list out directions for staff to follow in the instance that the participant has a seizure during a Respite event.
Basic Seizure First Aid:
- Stay calm and track the time
- Keep child safe
- Do not restrain
- Do not put anything in mouth
- Stay with the child until they are fully conscious
- Protect the head
- If tonic, clonic, place child on side and keep airway open for breathing

By signing below, I acknowledge that the information provided above is the most recent and up-to-date medical information for the above listed participant. In the event of an emergency, I give my permission for Easterseals Crossroads to seek emergency medical care and treatment from the physician and/or hospital that I have identified on the Respite Registration Forms. I understand that I am responsible for payment of any emergency medical care.

<table>
<thead>
<tr>
<th>If the participant has a typical seizure please do the following...</th>
<th>Call 911 immediately if...</th>
<th>Administer Diastat or utilize VNS magnet if....</th>
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<tbody>
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</table>

Parent Signature  
Date

For staff use only:  
This form was received and reviewed by:

Name / Title  
Date