Seizure Action Plan
Supplemental Form

easterseals Crossroads
taking on disability together

Participant Name: _____ Date: _____

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

Seizure Type	Length	Frequency	Description

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

Medication	Dose	Route of administration (i.e: oral, rectal, etc.)	The medication is for emergencies only
			☐ yes ☐ no
			☐ yes ☐ no
			☐ yes ☐ no

** 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.

If the participant has a typical seizure please do the following…	Call 911 immediately if…	Administer Diastat or utilize VNS magnet if….
1. 2. 3. 4. 5.		

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.

_____ _____

Parent Signature **Date**

For staff use only:

This form was received and reviewed by:

_____ _____

Name / Title **Date**