Acute Seizure Action Plan (ASAP)

This ASAP can be used in conjunction with your longer Seizure Action Plan. Having this shortened version may be helpful in the event of a seizure.

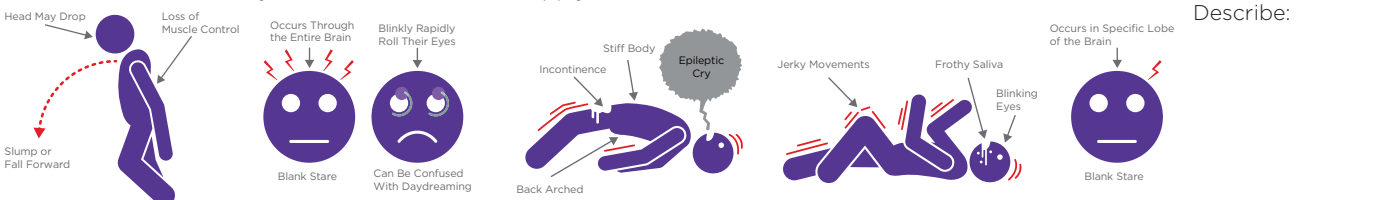
Name:	Birth date:	Today's date:
Care partner phone numbers:	Provider name/facility: Provider phone numbers: Telemedicine:	

Usual Seizure Pattern

Triggers:

Pattern of seizures:

What the seizures normally look like (Check all that apply)



Describe:

☐ Atonic seizure (also called drop)

☐ Absence seizure (also called petit mal)

☐ Tonic seizure

☐ Clonic seizure

☐ Focal impaired awareness seizure (also called complex partial)

NOTES:

Care

Standard Care Needed

If this happens,

provide standard care

Time the seizure

NOTES:

STAY with person

NOTES:

Keep person **SAFE.**

NOTES:

Turn the person onto their **SIDE**

NOTES:

Keep a record

NOTES:

Provide Rescue Treatment

If this happens,

provide standard care (above) and rescue treatment

☐ Rectum

☐ Nose

☐ Mouth

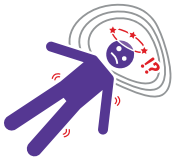
Specific instructions:

☐ Other:

Call for Emergency Help

If any of these happen,

☐ Seizure longer than ____ minutes



☐ Unusual seizure

☐ Injury/Blue lips

☐ Other:

Get help now

NOTES:

Healthcare provider name/phone number: :

Healthcare Provider Authorization

Signature: Provider Printed Name: Date: For use from: to: