SEIZURE PROTOCOL

Name:	
DOB:	
Address:	

Contact Information:

Title	Name	Home Phone	Cell phone	Work Phone
Contact 1				
Contact 2				
Emergency Contact 1				
Emergency Contact 2				

Medical Information:

Identification(s): (Formal Diagnosis)	
Medication(s): List **all** medications including dose and frequency	
Medication(s) administered during seizure only (please provide instructions)	
At what point should seizure medication be administered	

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History:

Please give a brief description of participants seizure history:	
Has participant ever been hospitalized because of seizures?	
How frequently do seizures take place (how many times a day, week, month etc.)	
Should 911 be called? (If yes, when?)	

Nature of Seizure:

Seizures Consist of: *(please tick off all that apply)*

- ☐ Shaking (where) _____
- ☐ Loss of consciousness
- ☐ Staring/Day dreaming
- ☐ Confusion
- ☐ Can hear but can't respond
- ☐ Loss of vision
- ☐ Picking at clothing or skin
- ☐ Blinking
- ☐ Turning to one side
- ☐ Raising arm
- ☐ Not breathing
- ☐ Foaming at the mouth
- ☐ Noisy or heavy breathing
- ☐ Rigidity
- ☐ Turning pale
- ☐ Turning red
- ☐ Sweating
- ☐ Screaming
- ☐ Hitting
- ☐ Head banging
- ☐ Biting tongue
- ☐ Wetting pants
- ☐ Smacking lips
- ☐ Flailing arms
- ☐ Other: _____

SEIZURE PROTOCOL

Warning Signs:

Signs of a seizure are: *(please tick off all that apply)*	
☐ Rising sensation ☐ Bad smell ☐ Fear ☐ Flashing lights ☐ Screaming ☐ Tingling (where? _____) ☐ Twitching (where? _____) ☐ Slurred speech ☐ Confusion	☐ Tremor ☐ Dizziness ☐ Tunnel Vision ☐ Shortness of breath ☐ Palpitation ☐ Sweating ☐ Sudden change in mood ☐ After eating certain foods _____ ☐ Other: _____

Individual Seizure Protocol:

Please describe the actions a staff person/caregiver should take before, during and after a seizure	

SEIZURE PROTOCOL

Recovery Period:

Are there any side affects after the seizure?	
☐ Confusion (how long?) _____ ☐ Weakness ☐ Numbness ☐ Agitation ☐ Sleepy ☐ Irritable ☐ Angry	☐ Blurred vision ☐ Difficulty speaking ☐ Depressed ☐ Euphoric ☐ Headaches ☐ Other: _____
Should parents be contacted? (If yes, when?)	

Additional Information:

Please provide any additional information that may be helpful to staff in providing the best care for the individual	

_____ _____ _____

Name of parent/guardian Signature of parent/guardian Date