# SEIZURE ACTION PLAN (SAP)

EPILEPSY FOUNDATION | END EPILEPSY

Name: _____ Birth Date: _____

Address: _____ Phone: _____

Emergency Contact/Relationship _____ Phone: _____

## Seizure Information

| Seizure Type | How Long It Lasts | How Often | What Happens |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

## How to respond to a seizure (check all that apply) ☑

- ☐ First aid – **Stay. Safe. Side.**
- ☐ Give rescue therapy according to SAP
- ☐ Notify emergency contact
- ☐ Notify emergency contact at _____
- ☐ Call 911 for transport to _____
- ☐ Other _____

## First aid for any seizure

- ☐ **STAY** calm, keep calm, **begin timing seizure**
- ☐ Keep me **SAFE** – remove harmful objects, don't restrain, protect head
- ☐ **SIDE** – turn on side if not awake, keep airway clear, don't put objects in mouth
- ☐ **STAY** until recovered from seizure
- ☐ Swipe magnet for VNS
- ☐ Write down what happens _____
- ☐ Other _____

## When to call 911

- ☐ Seizure with loss of consciousness longer than 5 minutes, not responding to rescue med if available
- ☐ Repeated seizures longer than 10 minutes, no recovery between them, not responding to rescue med if available
- ☐ Difficulty breathing after seizure
- ☐ Serious injury occurs or suspected, seizure in water

## When to call your provider first

- ☐ Change in seizure type, number or pattern
- ☐ Person does not return to usual behavior (i.e., confused for a long period)
- ☐ First time seizure that stops on its' own
- ☐ Other medical problems or pregnancy need to be checked

## When **rescue therapy** may be needed:

### WHEN AND WHAT TO DO

If seizure (cluster, # or length) _____

Name of Med/Rx _____ How much to give (dose) _____

How to give _____

If seizure (cluster, # or length) _____

Name of Med/Rx _____ How much to give (dose) _____

How to give _____

If seizure (cluster, # or length) _____

Name of Med/Rx _____ How much to give (dose) _____

How to give _____

## Care after seizure

What type of help is needed? (describe) _____

When is person able to resume usual activity? _____

## Special instructions

First Responders: _____

_____

Emergency Department: _____

_____

## Daily seizure medicine

| Medicine Name | Total Daily Amount | Amount of Tab/Liquid | How Taken (time of each dose and how much) |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

## Other information

Triggers: _____

Important Medical History _____

Allergies _____

Epilepsy Surgery (type, date, side effects) _____

Device: ☐ VNS ☐ RNS ☐ DBS Date Implanted _____

Diet Therapy ☐ Ketogenic ☐ Low Glycemic ☐ Modified Atkins ☐ Other (describe) _____

Special Instructions: _____

_____

### Health care contacts

Epilepsy Provider: _____ Phone: _____

Primary Care: _____ Phone: _____

Preferred Hospital: _____ Phone: _____

Pharmacy: _____ Phone: _____

*My signature* _____ Date _____

*Provider signature* _____ Date _____

**Epilepsy.com**


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EPILEPSY FOUNDATION | END EPILEPSY

# MEDICATION ADMINISTRATION AUTHORIZATION FORM for Youth Camps in Maryland

Maryland Department of Health (MDH)
Office of Healthy Homes and Communities
(410) 767-8417 or 1-877-463-3464 ext. 78417
Draft Revision Date: 4/4/2018

This form must be completed fully in order for youth camp operators and staff members to administer the required medication or for the camper to self-adminster medication. A new medication administration form must be completed at the beginning of each camp season, and each time there is a change in dosage or time of administration of a medication.

- Prescription medication must be in a container labeled by the pharmacist or prescriber.
- Nonprescription medication must be in the original container with the instructions for use. Non prescription medication includes vitamins, homeophathic, and herbal medicines.
- An adult must bring the medication to the camp and give the medication to an adult staff member.

## Section I. PRESCRIBER'S AUTHORIZATION

| 1. CHILD'S NAME (First Middle Last) | 2. DATE OF BIRTH (mm/dd/yyyy) ____/____/_____ |
|---|---|

| 3. MEDICATION SHALL BE ADMINISTERED during the year in which this form is dated in 7b below unless more restrictive dates are specified in 3a and 3b. This authorization is NOT TO EXCEED 1 YEAR. | 3a. FROM (mm/dd/yyyy) ____/____/_____ | 3b. TO (mm/dd/yyyy) ____/____/_____ |
|---|---|---|

| | Medication Name | Condition Being Treated/PRN Parameters | Dose | Route | Frequency | OK to Self-Administer | OK to Self-Carry (Emerg Meds Only) |
|---|---|---|---|---|---|---|---|
| 1 | | | | | | ☐ Yes ☐ No | ☐ Yes ☐ No ☐ Not emergency med |
| | | | *Emergency Medication: ☐ Yes ☐ No Known side effects:* | | | | |
| 2 | | | | | | ☐ Yes ☐ No | ☐ Yes ☐ No ☐ Not emergency med |
| | | | *Emergency Medication: ☐ Yes ☐ No Known side effects:* | | | | |
| 3 | | | | | | ☐ Yes ☐ No | ☐ Yes ☐ No ☐ Not emergency med |
| | | | *Emergency Medication: ☐ Yes ☐ No Known side effects:* | | | | |

| 4. PRESCRIBER'S NAME/TITLE | | | This space may be used for the Prescriber's Address Stamp |
|---|---|---|---|
| TELEPHONE | FAX | | |
| ADDRESS | | | |
| CITY | STATE | ZIP CODE | |

| 5a. PRESCRIBER'S SIGNATURE (Parent/guardian cannot sign here) (original signature or signature stamp only) | 5b. DATE (mm/dd/yyyy) |
|---|---|

## Section II. PARENT/GUARDIAN AUTHORIZATION

I request the authorized youth camp operator, staff member or volunteer to administer the medication or to supervise the camper in self-administration as prescribed by the above authorized prescriber. I certify that I have legal authority to consent to medical treatment for the child named above, including the administration of medication at the facility. I understand that at the end of the authorized period an authorized individual must pick up the medication; otherwise, it will be discarded. I authorize camp personnel and the authorized prescriber indicated on this form to communicate in compliance with HIPAA

| 6a. PARENT/GUARDIAN SIGNATURE | 6b. DATE (mm/dd/yyyy) | 6c. INDIVIDUALS AUTHORIZED TO PICK UP MEDICATION |
|---|---|---|

| 6d. HOME PHONE # | 6e. CELL PHONE # | 6f. WORK PHONE # |
|---|---|---|

## Section III. AUTHORIZATION FOR SELF-ADMINISTRATION / SELF-CARRY (OPTIONAL)

THIS SECTION SHOULD ONLY BE COMPLETED IF ANY MEDICATIONS IN THE ASTHMA ACTION PLAN ABOVE ARE APPROVED FOR SELF-ADMINISTRATION. Self-carry is only permitted for emergency medications such as inhalers and epinephrine. Both the prescriber and the parent/guardian must consent to self-administration below. However, youth camp operators are not required to permit self-administration or self-carry.

I authorize self-administration of all of the medications listed in *Section I* above that are checked as "OK to self-administer" or "OK to self-administer and self-carry" for the child named above under the supervision of the youth camp operator, a designated staff member or volunteer. If indicated in *Section I*, the child named above may self-carry emergency medications checked as "OK to self-administer and self-carry."

| 7a. PRESCRIBER'S SIGNATURE FOR SELF-ADMINISTRATION/SELF-CARRY | 7b. DATE | 8a. PARENT/GUARDIAN'S SIGNATURE FOR SELF-ADMINISTRATION/SELF-CARRY | 8b. DATE |
|---|---|---|---|