

MY SEIZURE PLAN

Name: _____ Birth Date: _____
 Address: _____ Phone: _____
 1st Emergency Contact: _____ Relation: _____
 Phone(s): _____ Email: _____
 2nd Emergency Contact: _____ Relation: _____
 Phone(s): _____ Email: _____

SEIZURE INFORMATION

Seizure Type/Nickname	What Happens	How Long It Lasts	How Often

TRIGGERS

DAILY SEIZURE MEDICINE

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

OTHER SEIZURE TREATMENTS

Device Type: _____ Model: _____ Serial#: _____ Date Implanted: _____
 Dietary Therapy: _____ Date Begun: _____
 Special Instructions: _____
 Other Therapy: _____