**CT Department of Developmental Services**

**Institutional Review Board (IRB)**

***Seizure Protocol/Action Plan Template***

***Overview****: A seizure is an event in which there is a temporary change in behavior that results from a sudden and abnormal burst of electrical activity in the brain. For example, an individual may experience confusion, loss of awareness, or uncontrolled body movements. Seizures may be partial or generalized. Epilepsy or seizure disorder is a chronic condition that is characterized by recurrent seizures. Acute, prolonged, or repetitive seizures are detrimental to an individual’s health.*

***The information below should be customized for the individual-served and used to assist caregivers in the event of a seizure.***

***Effective Date:***

**Personal Information**

|  |  |  |  |
| --- | --- | --- | --- |
| Individual’s Name |  | Date of Birth |  |
| Guardian |  | Phone |  |
| Other Emergency Contact |  | Phone |  |
| Treating Physician |  | Phone |  |
| Significant Medical History |  |

|  |  |
| --- | --- |
| Seizure Precautions |  |
| Seizure Triggers  |  |
| Seizure Warning Signs (e.g., aura) |  |
| Response After a Seizure Occurs |  |
| Protective Equipment Required |  |
| Process to Return to Routine |  |

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| --- |
| **Basic First Aid: Care and Comfort Measures** |
| Stay Calm and Track Time |
| Keep Individual Safe |
| Do Not Restrain/Stop Movements |
| Do Not Put Anything in Mouth |
| Do Not Offer Water or Food until Alert |
| Stay with Individual until Fully Conscious |
| Protect Head/Extremities |
| Keep Airway Open/Watch Breathing |
| Turn Individual on Side |
| Record Seizure in Log |

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| **A seizure is considered an *Emergency* if any of the following conditions occurs.** **Staff should call 9-11 immediately.** |
| Convulsions last longer than 5 minutes |
| Repeated seizures in a given timeframe (e.g., 24 hours) with or without loss of consciousness |
| A physical injury is sustained |
| Individual has a health condition like diabetes, heart disease, or pregnancy |
| It is a first-time seizure |
| Breathing difficulties are present |
| A seizure occurs in water |

**Seizure Treatment Protocol**

|  |  |  |  |
| --- | --- | --- | --- |
| **Medication** | **Dosage and Time of Day Given** | **Common Side Effects and Special Instructions** | **Clearly define the Maximum Dose per Medication** |
|  |  |  |  |
|  |  |  |  |
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| --- | --- | --- | --- |
| Does the individual have a Vagus Nerve Stimulator? | Yes | No | If Yes, Describe magnet use: |
| Special Considerations and Precautions (regarding activities, trips, etc.) | Please describe: |
| **Seizure Activity Log** |
| Dateand Time | Seizure Type | Level of Consciousness | Activity at Onset | Frequency of Seizures in Timeframe | Duration | Description |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |

*\*The Seizure Activity Log can be expanded into a separate document*

**Post-Seizure Assessment**

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| --- | --- |
| Vital sign monitoring? |  |
| What was the individual doing prior to the seizure? |  |
| Possible precipitating factors (e.g., stress, change in routine, decreased sleep)? |  |
| Was this seizure the first seizure or worse than previous ones? |  |
| Any recent medication changes? |  |
| Any current illnesses? |  |
| Schedule completed for a follow-up EEG? |  |

Reviewed by Healthcare Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_

Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_

I hereby grant my permission to share this medical information with staff in order to ensure the safety and well-being of the individual-served.