Seizure Action Plan
Easterseals Colorado Recreation Program

Camper Name: ____ Date of birth: ___________________

Type of seizure(s): ____

Date and description of last seizure: ____

Typical Seizure Description

Length of seizure (seconds or minutes): ____

Number of seizures typical per day/week/month/year: ____

Seizure triggers? ____

Warning signs or description of aura **BEFORE** seizures occur: ____

____

Body movements/ behavior **DURING** a seizure: ____

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____

Typical behavior **AFTER** a seizure (e.g. needs to nap, slurs speech, confusion for X minutes, back to normal, etc.): ____

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Seizure Protocol

When to administer rescue medications and how: ____

____

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When should caregiver/emergency contact be notified? ____

When should 911 be called? ____

Does the camper need to leave camp/day program after a seizure? ___________________________________

Any recent changes in treatment or medications? ____

____

Parent/ Guardian Name: _________________________________ Signature: __________________________

Physician Name: ____ Phone Number: ___________________

Physician Signature: ____ Date: ______________

***Please attach any further information you feel is helpful in the care of your camper during a seizure.**