# 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: _____

Diatery Therapy: _____ Date Begun: _____

Special Instructions: _____

Other Therapy: _____

THE EPILEPSY CENTER OF NORTHWEST OHIO

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