

Date: [Insert Date]

To: [Recipient Name/School/Employer/Care Facility]

Subject: Emergency Seizure Protocol for [Patient Name]

Patient Information:

Name: [Patient Name]

Date of Birth: [DOB]

Type of Seizures: [Type, e.g., Tonic-Clonic, Absence]

Standard First Aid Actions:

- Keep calm and stay with the person.
- Time the seizure from start to finish.
- Protect from injury (remove sharp objects, cushion head).
- Do not restrain the person.
- Do not put anything in their mouth.
- Roll the person onto their side once jerking stops to keep airway clear.

Emergency Medication (If applicable):

- Medication Name: [Name]
- Dosage: [Amount]
- Administration Instructions: [e.g., Nasal, Buccal]
- When to administer: [e.g., If seizure lasts longer than X minutes]

Call 911 (Emergency Services) If:

- The seizure lasts longer than [X] minutes.
- A second seizure starts shortly after the first.
- The person is injured, pregnant, or has diabetes.
- The person does not regain consciousness or has difficulty breathing.

Emergency Contact Information:

1. [Contact Name]: [Phone Number]
2. [Neurologist Name]: [Phone Number]

Physician Signature:

[Physician Name/Clinic Name]