Person's Name	Date of Birth	ProviderOne Number

Developmental Disabilities Administration (DDA)

Seizure Protocol

You do not need permission to call 911.

POLST DRN/I on file ☐ Yes ☐ No	Where is the POLST DNR/I located?	Date Signed

Call 911 and **START FIRST AID** as trained if:

1. The person is not breathing or having difficulties breathing.
2. The person is blue / gray in color.
3. The person's oxygen saturations are below .
4. The person has more than seizures in (e.g., minutes / hours / days).
5. The seizure lasts greater than .
6. Other:

After 911 has been notified, follow instructions from the dispatcher. Notify the dispatcher if there is a POLST DNR/I in place.

After calling 911 and stabilizing the person:

- Contact your supervisor.
- Document on seizure log.
- Document per agency protocol in the person's chart.

Notify doctor under the following circumstances:

☐ If the person has more than seizures in (e.g., 15 minutes, one hour, or daily).
☐ If the person has a seizure which looks different than past seizures:
☐ Other directions:

Notify health care provider by: ☐ Phone ☐ Fax ☐ Email:

Health care provider's contact information:

Health Care Provider's Name	Phone number	Fax number

Seizure Information

Seizure types: ☐ Focal ☐ Tonic-Clonic ☐ Absence ☐ Other:
What happens before I have a seizure:
What do my seizures look like:
How often do I have seizures:
How long do my seizures last:
What do I look like after having a seizure:
Vagal Nerve Stimulator (VNS): ☐ Yes ☐ No
If yes, list instructions for use:
Nurse Delegation in place for VNS: ☐ Yes ☐ No
I use the following medications when I am having a seizure:
☐ None **Rescue Medications and VNS Magnet must be available to the person when out of their home.**

Rescue Medicine	Medication Dose	When to administer	When to repeat	When to call 911

Do not delay creation of a protocol while awaiting medical provider approval.

Person's Name	Date of Birth	ProviderOne Number

I have the following safety precautions in place:

☐ Helmet: ☐ Yes ☐ No; if yes, please describe use:

☐ Side rails on bed: ☐ Yes ☐ No; if yes, has a health care provider or therapist (OT / PT) assessed for safety risk:

☐ Yes ☐ No; if yes, date completed:

☐ Safety belt while in wheelchair: ☐ Yes ☐ No; if yes, has a health care provider or therapist (OT / PT) assessed for safety risk: ☐ Yes ☐ No; if yes, date completed:

☐ Floor mat / pad: ☐ Yes ☐ No; if yes, please describe use:

☐ Bathing / swimming precautions: ☐ Yes ☐ No; if yes, please describe them:

☐ Eating precautions: ☐ Yes ☐ No; if yes, please describe them:

☐ How long after having a seizure should I wait to have food or fluids (due to aspiration risk):

☐ Other precautions:

Specific steps to take in the event I have a seizure:

1.
2.
3.
4.
5.
6.
7.
8.
9.

General steps to take if a seizure occurs:

1. Stay with the person until the seizure ends and they are fully awake.
2. Time the seizure.
3. Do not put anything in the person's mouth.
4. Move harmful objects away from the person and place something soft beneath their head.
5. Loosen tight fitting clothing (if able)
6. Protect the person's airway (turn to left side if able)
7. Once the person is awake and alert, move them to a safe place.
8. Explain in simple terms what happened and comfort the person.
9. Document details (time, date, duration, actions taken)

Plan Completed by:	Date Plan Completed
Health Care Provider's Signature	Date Signed
Health Care Provider's Name	Phone

Date of last review (enter signature and date):

Do not delay creation of a protocol while awaiting medical provider approval.