# MY SEIZURE PLAN

**Child's Name:**________________________ **Birth Date**:________________

**Parent Name:**________________________ **Phone**:________________

**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:__________

Dietary Therapy:____________________________ Date Begun:__________

Special Instructions:____________________________________

**Parent Signature:**____________________________________

ABA Development is a non-profit organization dedicated to enhancing the lives of children with intellectual disabilities.