When rescue therapy may be needed:

**WHEN AND WHAT TO DO**

If seizure (cluster, # or length)________________________
Name of Med/Rx _____________________________ How much to give (dose) _____________________________
How to give _____________________________

If seizure (cluster, # or length)________________________
Name of Med/Rx _____________________________ How much to give (dose) _____________________________
How to give _____________________________

If seizure (cluster, # or length)________________________
Name of Med/Rx _____________________________ How much to give (dose) _____________________________
How to give _____________________________
Care after seizure

What type of help is needed? (describe) _________________________________________________________________

When is person able to resume usual activity? ___________________________________________________________

Special instructions

First Responders: ____________________________________________________________

Emergency Department: ____________________________________________________________

Daily seizure medicine

<table>
<thead>
<tr>
<th>Medicine Name</th>
<th>Total Daily Amount</th>
<th>Amount of Tab/Liquid</th>
<th>How Taken (time of each dose and how much)</th>
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</table>

Other information

Triggers: ____________________________________________________________

Important Medical History: ____________________________________________________________

Allergies: ____________________________________________________________

Epilepsy Surgery (type, date, side effects): ____________________________________________________________

Device: [ ] VNS  [ ] RNS  [ ] DBS  Date Implanted __________________________

Diet Therapy: [ ] Ketogenic  [ ] Low Glycemic  [ ] Modified Atkins  [ ] Other (describe) ____________________________

Special Instructions: ____________________________________________________________

Health care contacts

Epilepsy Provider: ____________________________ Phone: ____________________________

Primary Care: ____________________________ Phone: ____________________________

Preferred Hospital: ____________________________ Phone: ____________________________

Pharmacy: ____________________________ Phone: ____________________________

My signature ____________________________ Date ____________________________

Provider signature ____________________________ Date ____________________________