

## Child Care Seizure Care Plan

To be completed by family

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Place Photo here

- Child needs to take daily medication for seizures when at center/school:  
 Yes (complete attached Medication Authorization Form)  No
- Child has a 3-day emergency supply of daily seizure medication at center/school:  
 Yes (complete attached 3-Day Critical Medication Form)  N/A

Hospital Preference: \_\_\_\_\_

My child's seizures look like: \_\_\_\_\_

\_\_\_\_\_

During a seizure, my child needs:	After a seizure:
<p><u>Basic Seizure First Aid</u></p> <ul style="list-style-type: none"> <li>▪ Stay calm and provide reassurance</li> <li>▪ Time, observe, record what happens</li> <li>▪ Protect my child from possible hazards (chairs, tables, sharp objects, etc.)</li> <li>▪ Do not restrain my child</li> <li>▪ Do not put anything in my child's mouth</li> <li>▪ Turn my child on side, if possible</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Document seizure activity in log</li> <li><input type="checkbox"/> Stay with my child until he/she is fully aware of his/her surroundings</li> <li><input type="checkbox"/> Provide comfort and emotional support</li> </ul>

To be completed by Health Care Provider (Nurse Practitioner or Physician)

"Emergency" Treatments			
Treatment (i.e. VNS magnet, emergency medication)	How much to give (dose)	When to give (i.e. "when seizure starts")	Common Side Effects & Special Instructions

<p><b>Treat child's seizure as an emergency if</b> (check all that apply):</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> A seizure begins</li> <li><input type="checkbox"/> A generalized convulsive seizure lasts longer than 5 minutes</li> <li><input type="checkbox"/> Child has __ or more seizures without recovering in between</li> <li><input type="checkbox"/> "Emergency" treatments above don't work</li> <li><input type="checkbox"/> Child is injured</li> <li><input type="checkbox"/> Child has breathing difficulties</li> <li><input type="checkbox"/> Child's behavior doesn't return to normal</li> <li><input type="checkbox"/> Child has a seizure in water</li> </ul>	<p><b>For seizure emergency:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Call 911 for transport to hospital</li> <li><input type="checkbox"/> Notify parent/guardian(s)/emergency contact</li> <li><input type="checkbox"/> Notify health care provider</li> <li><input type="checkbox"/> Administer Emergency medicine (see above)</li> <li>Other: _____</li> </ul>
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Special Considerations and Safety Concerns (for activities, sports, trips, etc.): \_\_\_\_\_



## Child Care Seizure Care Plan

**Health Care Provider:** My signature provides authorization for the above written orders (on Page 1 of Seizure Plan Packet). I understand that all procedures will be implemented in accordance with state laws and regulations. (This authorization is for a maximum of one year from health care provider's signature date.)

X \_\_\_\_\_  
Health Care Provider Name (printed)

( ) \_\_\_\_\_  
Phone Number

X \_\_\_\_\_  
Health Care Provider Signature (required)

X \_\_\_\_\_  
Date

**Parent/Guardian:** I agree with the above seizure care plan and emergency plan. I will inform the child care program if child's health status/medication changes.

\_\_\_\_\_  
Parent/Guardian Name (printed)

( ) \_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

### Emergency Contact Information

Emergency Contact #1	Phone:
Name: _____	( ) _____
Relation: _____	
Emergency Contact # 2	Phone:
Name: _____	( ) _____
Relation: _____	
Emergency Contact # 3	Phone:
Name: _____	( ) _____
Relation: _____	

### Staff Training Information

Staff Name	Trainer (parent or guardian)	Date

This Care Plan is on file with Emergency Medical Services (EMS) service closest to the child care site:  Yes  No



# SEIZURE ACTIVITY LOG

Note: This should be accompanied by an established *Seizure Care Plan* on-file for this child.

Name of Child: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Room: \_\_\_\_\_

DATE	TIME OF SEIZURE	CIRCUMSTANCES BEFORE (activity participating in)	DESCRIBE SEIZURE*	LENGTH OF SEIZURE	ACTIONS TAKEN BY STAFF	CHILD'S BEHAVIOR AFTER SEIZURE	STAFF NAME (person making entry)

**\*What to look for and note above:**

1. Sudden Stare
2. Unresponsive to name
3. Picking or fumbling movements of hands
4. Prompt recovery (seconds)
5. Gradual recovery (minutes)
6. Slow recovery (confused/ needing sleep)
7. Clenched jaw or tongue bitten
8. Unconsciousness
9. Color change or breathing problem
10. Stiff and/or jerky movements
11. Lip smacking
12. Eye fluttering



## Seizure Medication Authorization Form

(Please use one form per medication)

Child's Name:	Date of Birth/Age:
Name of Medication:	Reason for Medication: <b>seizures</b>
Medication Start Date:     ___/___/___	Medication Expiration Date = Stop Date:     ___/___/___
Times to be given:	Amount to be given:
Possible Side Effects:	Route: <input type="checkbox"/> Oral <input type="checkbox"/> Topical <input type="checkbox"/> Other _____
<input type="checkbox"/> Above information consistent with label?	Requires Refrigeration: <input type="checkbox"/> Yes <input type="checkbox"/> No
Special Instructions:	

\_\_\_\_\_  
Health Care Provider Name (please print)

( ) \_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Health Care Provider Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Name (please print)

( ) \_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

**Child Care Program Staff:** This form is active for a maximum of one year from health care provider's signature date (above), and should be renewed annually, or sooner if there are changes to medication or health condition. Authorization form is active from: \_\_\_/\_\_\_/\_\_\_ to \_\_\_/\_\_\_/\_\_\_.





