FORM F
Individualized Health Plan for Children with Seizures in Childcare

Child's Name _____ Birth date:_____ Age _____

Health Care Provider's Name _____

Health Care Provider's Phone _____

Health Care Provider's Address _____

Preferred Hospital _____ ER Phone # _____

Emergency Contact 1: _____ Emergency Contact 2: _____

Relationship _____ Relationship _____

Phone: _____ Phone: _____

SEIZURE INFORMATION

Type[s] of Seizure Disorder: _____

Approximately how long does your child's seizure last?_____

During the child's seizure, do you typically see:

	Yes	No		Yes	No
Arm movement			Leg Movement		
Staring			Loss of Bladder Control		
Eye Blinking			Falling Down		
Lip Smacking			'Spacing Out'		
Loss of Bowel Control			Other: (please describe)		

Some people routinely have responses before or after a seizure. Does your child have:

	Before Seizure	After Seizure
Confusion		
'Aura' - appearance		
Sleepy		
Other:		

What do you do when your child has a seizure?

What else must we know about your child's typical seizure?

MEDICATION

Please list all medicines your child takes at home and at school. For all *essential* medications, we ask for a 3 day supply to be kept here in case of an earthquake or other disaster.

Name of Medicine	Times Given	Dose and Method	Side Effects

Does this child require a 3-day emergency supply of medication at child care? Yes ☐ No ☐

If yes, please complete the 3-Day Emergency Medication Supply form

Emergency Plan for Children with Seizures in Childcare

Child's Name:_____Birth date:_____ Age:_____

If, (child's name)_____ **has a typical seizure (as described) while attending child care, we *will* do the following:**

- Cushion the child's head
- Loosen clothing around the neck, if appropriate
- After seizure, roll child on his side to prevent chocking
- Provide privacy, as able

We *will not*,

- Restrict movement, except to prevent injury
- give fluids

After the seizure, we *will*

- Document the seizure activity, including the length of the seizure
- Provide personal care, as needed
- Notify parents
- Other:

We *will call 911* if your child's seizure is different than described by you, or should the following occur:

- Duration of seizure lasts longer than ___ minutes
- A second seizure occurs
- Any difficulty breathing is noted
- Any blueness around the lips or fingernails is noted

I agree with the above classroom seizure management plan and emergency plan.

Parent signature _____ **Date** _____

Director's Signature _____ **Date**_____

Health Provider's Signature _____ **Date** _____

Revised 3/1/07

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