Public Health
Seattle & King County

Child Care Seizure Care Plan

To be completed by family

Child's Name: _____ **Date of Birth:** _____

Place Photo here

1. Child needs to take daily medication for seizures when at center/school:
   ☐ **Yes** (complete attached Medication Authorization Form) ☐ **No**

2. 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:
Basic Seizure First Aid ▪ Stay calm and provide reassurance ▪ Time, observe, record what happens ▪ Protect my child from possible hazards (chairs, tables, sharp objects, etc.) ▪ Do not restrain my child ▪ Do not put anything in my child's mouth ▪ Turn my child on side, if possible	☐ Document seizure activity in log ☐ Stay with my child until he/she is fully aware of his/her surroundings ☐ Provide comfort and emotional support

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

Treat child's seizure as an emergency if (check all that apply):	For seizure emergency:
☐ A seizure begins ☐ A generalized convulsive seizure lasts longer than 5 minutes ☐ Child has __ or more seizures without recovering in between ☐ "Emergency" treatments above don't work ☐ Child is injured ☐ Child has breathing difficulties ☐ Child's behavior doesn't return to normal ☐ Child has a seizure in water	☐ Call 911 for transport to hospital ☐ Notify parent/guardian(s)/emergency contact ☐ Notify health care provider ☐ Administer Emergency medicine (see above) Other: _____

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

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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

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Seizure Medication Authorization Form

(Please use one form per medication)

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

X_____ Health Care Provider Name (please print)

_(____)_____ Phone Number

X_____ Health Care Provider Signature

X_____ 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 ___/___/___.

Medication Record

(Must be filled out by the person who gives the medication)

Child's Name:
Name of Medication:

Date	Time	Dosage	Initials	Reason NOT Given	Side Effects Observed

Initials and signatures of persons giving medication:

____ _____ ____ _____

____ _____ ____ _____

3 -DAY CRITICAL MEDICATION AUTHORIZATION FORM

(These medications are only to be used in case of disaster requiring the child to remain in care past usual hours)

Child's Name:	Date of Birth/Age:
Name of Medication:	Reason for Medication:
Date to be replaced/rotated*: ____/____/____	Expiration date of medication: ____/____/____
☐ Scheduled times to be given (please list times below):	☐ To be given as needed for the following symptoms (please list symptoms below):
Dose (Amount to be given):	
Possible Side Effects:	Route: ☐ Oral ☐ Topical ☐ Other _____
☐ Above information consistent with label?	Requires Refrigeration: ☐ Yes ☐ No
Special Instructions:	

* Maximum 6 months - sooner as needed.

Parent/Guardian: Please be sure to inform child care program if child's health status/medication changes

_____ _____

Parent/Guardian Signature Date

_(____)_____

Daytime Phone Number

_____ _____

Health Care Provider Signature Date

_(____)_____

Health Care Provider Phone Number