Individualized Health Care Plan for a Child with Seizure Disorder

Working in collaboration with the child's parent and Health Care Provider, the following health care plan was developed to meet the needs of:

Child's name:	Child's date of birth:
Name of child's Health Care Provider:	☐ Physician ☐ Physician Assistant ☐ Nurse Practitioner

Describe the special health care needs of this child and the plan of care as identified by the parent and child's health care provider. This should include information completed on the Medical Statement.

Medications at home:
Medications at child care:
Describe a typical seizure:
Action to be taken during and after seizure:

Information specific to this child's seizure disorder:
Known Triggers for this child's seizures (circle all that apply):

flashing lights	lack of sleep	illness/fever
excitement/stress	lack of food	caffeine
foods (specify):		
other (specify):		

Warning Signs this child displays when a seizure might happen (circle all that apply):

jerking arm, leg, or body	daydreaming episodes	falling
feeling spacey, confused	unusual smell/taste	headaches
losing bowel/bladder control	forgetfulness/memory lapses	sleepiness
other (specify):		

Seizure First Aid:
- o Keep calm: provide reassurance, remove bystanders
- o Keep airway clear: turn on side, nothing in mouth
- o Keep safe: Remove objects, do not restrain
- o Document: Note time, observe/record what happens
- o Stay with child until recovered
- o Other:

Call 911 for:
- o Generalized seizure longer than 5 minutes
- o Emergency medications don't work
- o Two or more seizures without recovering between
- o Injury occurs or seizure occurs in water
- o Other:

Call parent/guardian for:
- o All above
- o Other:

Child's name:

Staff to care for child and staff training:
Identify the program staff that will care for this child with seizure disorder:

Staff name:	Credentials or professional license information*

Describe any additional training, procedures, or competencies that the staff identified will need to carry out the health care plan as identified by the parent or health care provider. This should include information from the Medical Statement or information shared post enrollment. In addition, describe how this additional training and competency will be achieved including who will provide this training.

Signature of Authorized Program Representative
I understand that it is my responsibility to follow the above plan and all health and infection control day care regulations related to the modality of care I provide. This plan was developed in close collaboration with the child's parent and the child's health care provider. I understand that it is my responsibility to see that those staff identified to provide all treatments and administer medication to the child listed in the specialized health care plan have a valid MAT certificate, CPR, and First Aid certifications or have a license that exempts them from training and have received any additional training needed and have demonstrated competency to administer such treatment and medication in accordance with the plan identified.

Provider/Facility name:	Facility ID number:	Facility telephone number:
Authorized child care provider name (please print):		Date:
Authorized child care provider signature:		
Parent/Guardian name (please print):		Date:
Parent/Guardian signature:		