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.)

_____ _(____)_____
Health Care Provider Name (printed) Phone Number

_____ _____
Health Care Provider Signature (required) 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**