Seizure Care Plan

A seizure care plan defines all members of the team, communication guidelines (how, when, and how often) and all information necessary to support a child who may experience seizures while in child care.

Name of child: ___________________________ Date: ___________________________

Facility name: __________________________________________________________________

Description of seizure condition/disorder: ________________________________________
____________________________________________________________________________

Describe what the child’s seizures look like: (What part of the body is affected? How long do seizure episodes usually last?)
____________________________________________________________________________
____________________________________________________________________________

Describe any known “triggers” (behaviors and/or symptoms) for seizure activity:
____________________________________________________________________________
____________________________________________________________________________

Detail the frequency and duration of child’s typical seizure activity:
Has the child been treated in the emergency room due to their seizures? ________ How many times? ________
Has the child stayed overnight in the hospital due to their seizures? __________ How many times? ________

Team Member Names and Titles: (parents of the child are to be included)
Care Coordinator (responsible for developing and administering the Special Health Care Plan): ________________
____________________________________________________________________________
____________________________________________________________________________

If training is necessary, then all team members will be trained.

Planned strategies to support the child’s needs and safety issues when the child has a seizure:
(e.g., diapering/toileting, outdoor play, nap/sleeping, etc)
____________________________________________________________________________
____________________________________________________________________________

☐ Individualized Family Service Plan (IFSP) attached  ☐ Individualized Education Plan (IEP) attached

<table>
<thead>
<tr>
<th>Problem</th>
<th>Treatment</th>
<th>Expected Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>At risk for injury due to uncontrolled seizure activity.</td>
<td>If a seizure occurs, staff will remove objects from the area and place a folded towel/clothing beneath the child’s head. Protective helmet is worn as prescribed.</td>
<td>Injuries related to seizure activity will be prevented.</td>
</tr>
<tr>
<td>At risk for aspiration of respiratory secretions or vomitus during seizure.</td>
<td>If a seizure occurs, staff will roll the child onto his/her side.</td>
<td>Child will not aspirate during seizure activity.</td>
</tr>
<tr>
<td>Self-esteem disturbance related to occurrence of seizure or use of protective helmet.</td>
<td>Provide many opportunities for success. Praise achievements and accomplishments. Provide opportunities for child to express feelings about seizures and any activity restrictions. Reassure the other children in the group that the child will be OK if a seizure occurs.</td>
<td>The child will successfully adapt to requirements of living with a seizure disorder. The child will demonstrate a positive attitude toward learning activities. Other children will feel safe.</td>
</tr>
<tr>
<td>Parent and child may not be aware of possible triggers.</td>
<td>Staff will document the occurrence of any seizure activity on attached Seizure Activity Log.</td>
<td>Parents, staff and the child will learn to identify triggers and how to avoid them.</td>
</tr>
<tr>
<td>Child may be very sleepy, but not unresponsive after a seizure occurs.</td>
<td>Staff will make sure that the child is responsive after a seizure, then will allow the child to sleep/rest after the seizure.</td>
<td>The child may safely sleep/rest, if needed, after seizure occurs.</td>
</tr>
</tbody>
</table>
**Communication**

How the team will communicate (notes, communication log, phone calls, meetings, etc.):

How often will team communication occur:
- [ ] Daily
- [ ] Weekly
- [ ] Monthly
- [ ] Bi-monthly
- [ ] Other

Date and time specifics:

**Outside Professionals Involved**

<table>
<thead>
<tr>
<th>Professional</th>
<th>Telephone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Care Provider (MD, NP, etc.)</td>
<td></td>
</tr>
<tr>
<td>Occupational Therapist</td>
<td></td>
</tr>
<tr>
<td>Physical Therapist</td>
<td></td>
</tr>
<tr>
<td>Neurology Speciality</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>

**Specific Medical Information**

- Medical documentation provided and attached: [ ] Yes  [ ] No
- Information Exchange Form completed by health care provider is in child’s file on site: [ ] Yes  [ ] No
- Any known allergies to foods and/or medications: ____________________________________________
- Medication to be administered: [ ] Yes  [ ] No
- Medication Administration Form completed by health care provider and parents are in child’s file on site (including: type of medications, method, amount, time schedule, potential side effects, etc.): [ ] Yes  [ ] No

**Special Staff Training Needs**

Type (be specific): ____________________________________________

Training done by: ____________________________________________ Date of Training: _______________

**Additional Information** (include any unusual episodes/behavior changes that might arise while in care and how the situation should be handled)

__________________________________________________________________________________________

__________________________________________________________________________________________

__________________________________________________________________________________________

**Support Programs the Child Is Involved with Outside of Child Care**

<table>
<thead>
<tr>
<th>Name of Program</th>
<th>Address and Telephone</th>
<th>Contact Person</th>
</tr>
</thead>
</table>

**Emergency Procedures**

- [ ] Special emergency and/or medical procedure required (additional documentation attached)

Emergency instructions:

__________________________________________________________________________________________

Call 911 if:
- [ ] Seizure lasts longer than ______ minutes
- [ ] If child is unresponsive after seizure
- [ ] Other ______________

Emergency contact: __________________________ Telephone: __________________________

**Follow-up: Updates/Revisions**

This Special Health Care Plan is to be updated/revised whenever child’s health status changes or at least every ________ months as a result of the collective input from team members.

Due date for revision and team meeting: _______________________

Resources: California Childcare Health Program. [www.ucsfchildcarehealth.org](http://www.ucsfchildcarehealth.org)

Form provided by Child Care Aware® of North Dakota Health Consultants.

Revised 8/19

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