



INDIVIDUAL HEALTH PLAN/EMERGENCY CARE PLAN FOR CHILD WITH SEIZURES

Child's Name: _____ Birth Date: _____

Program Name/Site: _____ Grade: _____

1. **My child has seizures.**

YES Complete form, sign, date, and return it to the CE Program your child attends.

NO Parent/Guardian Signature: _____ Date: _____
(If "NO" is checked, do not fill out the remainder of the form, just sign, and return it)

2. Check the type of seizure your child has:

Generalized tonic-clonic: Muscles become rigid with convulsive movements and impaired consciousness

Complex partial (focal impaired awareness): May consist of purposeless activity, not aware of what is happening

Simple partial (focal aware): Jerking of one limb or side of body, consciousness maintained

Absence: Brief interruption of consciousness often characterized by an appearance of daydreaming

3. **List any known seizure triggers:** _____

4. Describe any warnings and/or behavior changes before the seizure:

5. Any recent changes in your child's seizure patterns: **YES** **NO**

If yes, explain: _____

6. Describe what happens *during* the seizure:

7. Describe what happens *after* the seizure:

8. How long does seizure last? _____

9. Approximate date of last seizure: _____

10. How frequent are seizures? daily weekly monthly yearly

11. Medication your child takes at home for seizures: _____

12. Will your child need any treatment or medication during CE program for seizures: **YES** **NO**

If yes, explain: _____

If medication is needed at the program, complete the [Consent Form for Administration of Medication](#)

Child's Name: _____

13. Are there any special considerations or precautions regarding program activities and field trips?

YES NO

If yes, explain: _____

14. HEALTH CARE PROVIDER NAME: _____ PHONE: _____

CLINIC: _____ FAX: _____

Emergency Contacts: (list in order of who to call first)

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

CE ACTION/EMERGENCY PLAN

If student has a seizure during the CE program, staff will do the following:

- ❖ Stay with child
- ❖ Protect child and provide privacy
- ❖ Note the time the seizure begins and ends
- ❖ Give emergency seizure medication if ordered by provider
- ❖ Notify program supervisor and contact parent/guardian

911 will be called if ANY of the following occur: *(notify program supervisor and parent when 911 is called)*

- ❖ Seizure lasts more than **three** minutes (unless otherwise indicated by the health care provider).
- ❖ Child has difficulty breathing after seizure has ended
- ❖ Child aspirates
- ❖ Child becomes injured during seizure or seizure occurs in the water
- ❖ Child has repeated seizures without regaining consciousness

PARENT/GUARDIAN AUTHORIZATION

1. I understand that this plan may be shared with all CE staff working directly with my child.
2. I will contact the CE program coordinator/supervisor if a change in the current plan is indicated.
3. I authorize the CE program coordinator/designee and health care provider to exchange information related to my child's seizure plan and medication.

Parent/Guardian Signature: _____ **Date:** _____