

# Seizure Care Plan

The 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:** (1) what part of the body is affected? (2) How long do the seizure episodes usually last?

**Describe any know "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 Seizure 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.

PROBLEM	TREATMENT	EXPECTED RESPONSE
At risk for injury due to uncontrolled seizure activity.	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.	Injuries related to seizure activity will be prevented.
At risk for aspiration of respiratory secretions or vomitus during seizure activity.	If a seizure occurs, staff will roll the child onto his/her side.	Child will not aspirate during seizure activity.
Self-esteem disturbance related to occurrence of seizure or use of protective helmet.	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.	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.
Parent and child may not be aware of possible triggers.	Staff will document the occurrence of any seizure activity on attached <i>Seizure Activity Log</i> .	Parents, staff and the child will learn to identify triggers and how to avoid them.
Child may be very sleepy, but not unresponsive after a seizure occurs.	Staff will make sure that the child is responsive after a seizure, then will allow the child to sleep/rest after the seizure.	The child may safely sleep/rest, if needed, after seizure occurs.

**Communication**

What is the team's communication goal and how will it be achieved (e.g., notes, communication log, phone calls, meetings, etc.): \_\_\_\_\_

How often will team communication occur:     **Daily**     **Weekly**     **Monthly**     **Bi-monthly**

Date and time specifics: \_\_\_\_\_

**Other Professionals Involved**

**Telephone**

Health Care Provider (MD, NP, etc.): \_\_\_\_\_

\_\_\_\_\_

Occupational Therapist: \_\_\_\_\_

\_\_\_\_\_

Physical Therapist: \_\_\_\_\_

\_\_\_\_\_

Neurology Specialist: \_\_\_\_\_

\_\_\_\_\_

Other: \_\_\_\_\_

\_\_\_\_\_

**Specific Medical Information**

❖ Medical documentation provided & attached:  Yes  No

**Information Exchange Form** completed by Health Care Provider on-file.

Any known allergies to food and/or medications: \_\_\_\_\_

❖ Medication to be administered:  Yes  No

**Medication Administration Form** completed by Health Care Provider and parents is on file (including: type of medications, method, amount, time schedule, potential side effects, etc.)

**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 Program the Child is Involved With Outside of Child Care**

Name of program: \_\_\_\_\_

Address and telephone: \_\_\_\_\_

Contact person: \_\_\_\_\_

**Emergency Procedures**

*Special emergency and/or medical procedure required.* Emergency instructions: \_\_\_\_\_

\_\_\_\_\_

❖ Call 911 if:  Seizure lasts longer than \_\_\_\_ minutes.  Child is unresponsive after seizure.

Other: \_\_\_\_\_

Emergency contact: \_\_\_\_\_

Telephone: \_\_\_\_\_

**Follow-up: Updates/Revisions**

This *Seizure Care Plan* will be updated/revised whenever medications or child's health status changes, or at least every 12 months as a result of the collective input from team members.

Date for revision and team meeting: \_\_\_\_\_