

Seizure Health Care Plan

Child's Name: _____ DOB: _____

Parent/Guardian Name: _____ Phone: _____

Physician's Name: _____ Phone: _____

The following information should be completed by the child's health care provider:

Diagnosis: _____

Describe the 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 known "triggers" (behaviors and/or symptoms) for seizure activity: _____

Detail the frequency and duration of child's typical seizure activity: _____

Planned strategies to support the child's needs and safety issues when the child has a seizure, including calling 911: _____

Is child able to participate in all activities? ☐ No ☐ Yes If no, identify any limitations while at the center: _____

Are any medications required? ☐ No ☐ Yes If yes, list medications, dosage, frequency and any possible side effects. _____

**For complete medication administration information, it may be necessary for the medical provider and parent/guardian to complete the Medication Authorization form.*

Does the child have any dietary restrictions/allergies? ☐ No ☐ Yes If yes, please list. _____

Notify the parent/guardian of any seizures episodes promptly.

I. The Parent/Guardian will:

- Notify the staff of any known neurological changes and /or recent seizure episodes.
- Notify management of any medication changes.
- Provide the program with an accurate emergency contact list of numbers and individuals who will attend to the child in the event the parent is unavailable.
- Update the Emergency Contact Form immediately if any changes occur.

For MA centers only:

Staff may be trained by: _____

The following staff have been trained on the child's medical condition:

Physician Signature _____

Date _____

Parent/Guardian Signature _____

Date _____

Director/Principal Signature _____

Date _____

Parent/Guardian Acknowledgement Statement

To ensure the safety of your child we cannot delete a health care diagnosis which has previously been documented unless we have a signed note from the child's physician stating that the condition no longer exists; nor can we add an item(s) or change a medication without a signed note from the child's physician.

I understand that Bright Horizons requires the most up to date information regarding my child's health. I also understand that for the safety of my child, my child's photograph and health information will be posted in the classrooms and kitchen.

Parent/Guardian Signature _____

Date _____

This plan must be updated annually or whenever there is any change in treatment or the child's condition changes.