**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ HEAD START SEIZURE ACTION HEALTH CARE PLAN**

**This form must be completed and signed by a Health Care Provider**

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| **Child Name: \_ DOB: CLASS #: \_\_\_**  **Provider Name: Phone #: Fax #:** **Parent/Guardian Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Seizure Information****Type of seizure: Description of student’s seizure activity: How often do the seizures occur: Typical duration: Date of last seizure: Seizure triggers or warning signs**: **Student’s reaction/behaviors after seizure:**  **Dietary Restrictions:** Not applicable or Special Diet **Activity Restrictions:** None or Special Instructions  |
| **Routine Seizure Management****Routine Medications:*** Not applicable
* Medication name: Dosage/frequency: Given at school: Y N Time: Instructions:
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Does medication need to be available during bus transportation?  Yes  No (Medication only transported if yes is indicated) |
| **Emergency Seizure Action Plan(If child has a seizure…..)****For seizures lasting greater than minutes OR or more seizures in hours, CALL 911 and/or refer to Emergency Medication orders below.****Emergency Medications: (medication authorizations must be completed) \*staff of HeadStart will need trained by provider to administer Diastat*** Diastat: Dosage/frequency:

**911 will be called when Diastat is administered*** Other: Name Dosage/frequency :
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**SIGNATURES: This Seizure Health Action Plan has been approved by:**

Healthcare Provider Date E-mail

I give my permission to the Head Start, Head Start licensed/unlicensed assistive personnel, and other designated staff member(s) to perform and carry out the care tasks as outlined by this Seizure Action Plan for my child, and I acknowledge that I have received a copy of the signed plan.

Parent/Guardian Phone Date E-mail