This page to be completed by:
Program Staff and Parent or Guardian

Public Health
Seattle & King County

Seizure Care Plan Request Form

Child's name: _____

Child's date of birth: _____

Early Learning or Child Care Program Director: Michael Gwaltney

Early Learning or Child Care Program: Bellevue Children's Academy

Mailing Address: 14600 NE 24th St. Bellevue, WA 98007

Phone Number: 425-649-0791

Fax Number: _____

Healthcare Provider: The child listed above attends our program. This packet includes forms to help meet our licensing standards for medications and individual care plans. **Please complete pages 2-5**. These are forms that require a healthcare provider's instructions and signature.

By signing below, I give permission to my child's healthcare provider to release the health information requested in the following care plan to my child's program.

Parent or Guardian Name (Printed): _____

Parent or Guardian Signature: _____

Date: _____

Parent or Guardian Phone Number: _____

SEIZURE ACTION PLAN (SAP)

EPILEPSY FOUNDATION

Name: _____ Birth Date: _____

Address: _____ Phone: _____

Emergency Contact/Relationship: _____ Phone: _____

Seizure Information

Seizure Type	How Long It Lasts	How Often	What Happens

How to respond to a seizure (check all that apply)

- ☐ First aid – **Stay. Safe. Side.**
- ☐ Give rescue therapy according to SAP
- ☐ Notify emergency contact
- ☐ Notify emergency contact at _____
- ☐ Call 911 for transport to _____
- ☐ Other _____

First Aid for any seizure

- ☐ **STAY** calm, keep calm, begin timing seizure
- ☐ Keep me **SAFE** – remove harmful objects, don't restrain, protect head
- ☐ **SIDE** – turn on side if not awake, keep airway clear, don't put objects in mouth
- ☐ **STAY** until recovered from seizure
- ☐ Swipe magnet for VNS
- ☐ Write down what happens

_____

- ☐ Other

_____

When to call 911

- ☐ Seizure with loss of consciousness longer than 5 minutes, not responding to rescue med if available
- ☐ Repeated seizures longer than 10 minutes, no recovery between them, not responding to rescue med if available
- ☐ Difficulty breathing after seizure
- ☐ Serious injury occurs or suspected, seizure in water

When to call your provider first

- ☐ Change in seizure type, number or pattern
- ☐ Person does not return to usual behavior (i.e., confused for a long period)
- ☐ First time seizure that stops on its' own
- ☐ Other medical problems or pregnancy need to be checked

When **rescue therapy** may be needed:

When and What to do

If seizure (cluster, # or length) _____

Name of Med/Rx _____ How much to give (dose) _____

How to give _____

If seizure (cluster, # or length) _____

Name of Med/Rx _____ How much to give (dose) _____

How to give _____

If seizure (cluster, # or length) _____

Name of Med/Rx _____ How much to give (dose) _____

How to give _____

 Revised 03/2023 130SRP/PAB1216

Care after seizure

What type of help is needed? (describe) _____

When is person able to resume usual activity? _____

Special instructions

First Responders: _____

_____

Emergency Department: _____

_____

Daily seizure medicine

Medicine Name	Total Daily Amount	Amount of Tab/Liquid	How Taken (time of each dose and how much)

Other information

Triggers: _____

Important Medical History: _____

Allergies: _____

Epilepsy Surgery (type, date, side effects) _____

Device: ☐ VNS ☐ RNS ☐ DBS Date Implanted _____

Diet Therapy: ☐ Ketogenic ☐ Low Glycemic ☐ Modified Atkins ☐ Other (describe) _____

Special Instructions: _____

_____

Health care contacts

Epilepsy Provider: _____ Phone: _____

Primary Care: _____ Phone: _____

Preferred Hospital: _____ Phone: _____

Pharmacy: _____ Phone: _____

My signature: _____ Date _____

Provider Signature: _____ Date: _____

Revised 03/2023 130SRP/PAB1216

This page to be completed by:
Healthcare Provider

Public Health
Seattle & King County

3-Day Critical Medication Authorization Form

Healthcare Provider and Parent or Guardian: In the event the child needs to remain at the program past usual hours, a 3-day supply of Critical Medication(s) must be kept at the program. This life-sustaining medication is usually given when the child is not in care. Examples may include certain diabetes, seizure, or asthma medications. A new 3-Day Critical Medication Authorization Form should be completed if there are changes to the medication or child's health condition.

Program Staff: This life-sustaining medication will only be given if the child needs to remain at the program past usual hours. Each 3-Day Critical Medication must have its own 3-Day Critical Medication Authorization Form. Never give an expired medication. An expired medication must be replaced, and the updated expiration date must be added to this form.

Child's name: _____

Child's date of birth: _____

Name of medication: _____

Reason for medication: _____

Possible side effects of medication: _____

Medication expiration date: _____

When to give medication (do not write 'as needed' or 'ongoing'; list symptoms or times of day to give the medication)**:** _____

How much medication to give (must include dose of medication)**:** _____

How long to give medication (do not write 'as long as needed' or 'ongoing'; write a date to stop giving medication, no longer than 1 year)**:** _____

How to give the medication (for example: by mouth [oral], on skin [topical], injection, etc.)**:** _____

Public Health
Seattle & King County

3-Day Critical Medication Authorization Form (Continued)

Medication requires special storage: ☐ Yes ☐ No

If yes, specify (for example: refrigerate; keep away from light; etc.)**:**_____

Additional instructions: _____

Parent or Guardian: By signing below, I give the program permission to give this medication to my child as described on this 3-Day Critical Medication Authorization Form.

Parent or Guardian Name (Printed)**:** _____

Parent or Guardian Signature: _____

Date: _____

Healthcare Provider: By signing below, I acknowledge that this child requires a 3-Day supply of Critical Medication to be stored at the child's program**. It will only be given in the event the child needs to remain at the program past usual hours.**

Healthcare Provider Name (Printed): _____

Healthcare Provider Signature: _____

Healthcare Provider Phone Number: _____

Date: _____

This page to be completed by:
Program Staff and Parent or Guardian

Public Health
Seattle & King County

Additional Requirements for Care Plans

Child's name: _____

Program Staff and Parent or Guardian: The WAC requires that all care plans include the potential side effects and expiration date of medications. If this is not included in the care plan, write them in the table below. **You may find this information on the medication packaging or label.**

Medication Name	Expiration Date	Potential Side Effects

Program Staff and Parent or Guardian: The WAC requires a parent**,** guardian, or appointed designee to provide training to program staff about medication administration or special medical procedures listed in the child's care plan. **Use the space below to document this training.**

Employee Training Record				
Date of Training	**Employee Name (Printed)**	**Employee Signature**	**Trainer Name (Printed)**	**Trainer Signature**

Program Staff and Parent or Guardian: The WAC requires written consent from a child's parent or guardian before a program can administer any medications or follow a care plan that is completed by a healthcare provider. **Please have the parent or guardian sign below.**

By signing below, I give the program permission to follow this care plan as ordered by the healthcare provider.

Parent or Guardian Name (Printed)**:** _____

Parent or Guardian Signature: _____

Date: _____

This page to be completed by:
Parent or Guardian

Public Health
Seattle & King County

Emergency Contact Information

Child's name: _____

Parent or Guardian: If your child has a medical emergency, program staff need to be able to contact you or another emergency contact as quickly as possible. Please complete the following:

Emergency Contact #1

Name: _____

Relationship to Child: _____

Phone Number: _____

Emergency Contact #2

Name: _____

Relationship to Child: _____

Phone Number: _____

Emergency Contact #3

Name: _____

Relationship to Child: _____

Phone Number: _____

This page to be completed by: Program Staff

Public Health
Seattle & King County

Seizure Activity Log

Program Staff: Please provide a copy of this log to emergency medical services (EMS) and the child's parent or guardian. You must keep a copy of this log in the child's records per WAC. **Print additional Seizure Activity Logs as needed.**

Child's name: _____ **Child's date of birth:** _____

Date	Time of Seizure		What Happened Before Seizure Began	Seizure Symptoms*	Behavior after Seizure**	Actions Taken by Staff	If Applicable		Name of Person Documenting
	Start	End					Time Medication Given***	Time 911 Called	

***Seizure Symptoms:**

- Sudden stare
- Unresponsive to name
- Clenched jaw or tongue bitten
- Unconsciousness
- Color change or breathing problem
- Stiff or jerky movements
- Lip smacking or eye fluttering
- Any other symptoms from the seizure care plan

****Post-Seizure Behaviors:**

- Prompt recovery (seconds)
- Gradual recovery (minutes)
- Slow recovery (confused or needing to sleep)

*****Also complete the Medication Log**

This page to be completed by:
Program Staff

Public Health
Seattle & King County

Medication Log

Program Staff: Please print a Medication Log for each medication (including any 3-Day Critical Medication).

Child's name: _____

Child's date of birth: _____

Name of medication: _____

Date	Time	Dose	Person Giving Medication (*Initials)	Reason Medication Was Not Given	Observed Side Effects

Initials*	Printed Name and Signature of Person Giving Medications

This page to be completed by:
Program Staff and Parent or Guardian

Public Health
Seattle & King County

Controlled Substance Medication Log for Seizures

Program Staff: Some medications are "controlled substances," meaning the medication is regulated by the federal government due to potential for abuse. Seizure **rescue medications** are controlled substances and must be stored in a locked container (like a bank bag with key attached) and in a Grab and Go bag to be accessible at all times. Each controlled substance must have its own Controlled Substance Medication Log.

Child's name: _____

Child's date of birth: _____

Name of medication: _____

Amount or quantity of medication received by program: _____

Signature of program director: _____

Signature of parent or guardian: _____

Amount or quantity of medication returned to parent or guardian: _____

Signature of program director: _____

Signature of parent or guardian: _____

Date	Time	Dose	Starting Amount or Quantity	Amount or Quantity Given	Staff 1 *Initials	Staff 2 *Initials (Witness)

This page to be completed by:
Program Staff and Parent or Guardian

Public Health
Seattle & King County

Date	Time	Dose	Starting Amount or Quantity	Amount or Quantity Given	Staff 1 *Initials	Staff 2 *Initials (Witness)

***Initials and signatures of individuals giving the medication and witnessing the medication administration:**

Initials	Printed Name and Signature of Staff 1 and Staff 2