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:** Amy Lonac

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

**Mailing Address:** Bellevue Children's Academy, South Campus - BCA 1, 14600 NE 24th St., Bellevue, WA 98007
Bellevue Children's Academy, South Campus - BCA 2, 14640 NE 24th St., Bellevue, WA 98007

**Phone Number:** 425-649-0791 - BCA 1 (Opt. 1); BCA 2 (Opt. 2)

**Fax Number:** bca1@bcacademy.com; bca2@bcacademy.com

**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) |
|---|---|---|---|
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## 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: _____



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This page to be completed by:
Healthcare Provider

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# 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.)**:** _____

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# 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 |
|---|---|---|
| | | |
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**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** |
| | | | | |
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**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

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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

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# 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 | |
| | | | | | | | | | |
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***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

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# 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 |
|---|---|---|---|---|---|
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| Initials* | Printed Name and Signature of Person Giving Medications |
|---|---|
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This page to be completed by:
Program Staff and Parent or Guardian

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# 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) |
|---|---|---|---|---|---|---|
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| Date | Time | Dose | Starting Amount or Quantity | Amount or Quantity Given | Staff 1 *Initials | Staff 2 *Initials (Witness) |
|---|---|---|---|---|---|---|
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***Initials and signatures of individuals giving the medication and witnessing the medication administration:**

| Initials | Printed Name and Signature of Staff 1 and Staff 2 |
|---|---|
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