Bright Horizons
Seizure Health Care Plan

Child's Name: _____ DOB: _____

Parent/Guardian Name: _____ Phone: _____

Physician's Name: _____ Phone: _____

To be completed by the child's health care provider:

Diagnosis (include seizure type, frequency, duration): _____

_____

_____

Seizure triggers: _____

_____

_____

Changes in behavior/symptoms to watch for which may precede a seizure and action to be taken, including calling 911:_____

_____

_____

Describe child's seizures/response after seizure:_____

_____

_____

Are any medications required (include daily and emergency medications; special instructions for use/administration)? ☐ No ☐ Yes If yes, list medications, dosage, frequency and any possible side effects.

_____

_____

_____

Is child able to participate in all activities (including sports and field trips)? ☐ No ☐ Yes If no, identify any limitations/special considerations/precautions while at the center: _____

_____

_____

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

_____

_____

Potential consequence to child if treatment is not administered: _____

_____

_____

The center will promptly notify the parent/guardian of any seizure.

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 a current emergency contact list of numbers and individuals who will attend to the child in the event the parent/guardian 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