BOYS & GIRLS CLUBS
OF THE RED RIVER VALLEY

Individual Child Care Plan (ICCP): Seizures

Child's Name:____ **DOB:**_________________________

Site Location:____

Diagnosed Medical Condition:____

Is this a current health issue? YES____ NO____

If yes, how often does the condition occur:____

What symptoms and behaviors does your child experience?

Before the seizure:____

During the seizure:____

After the seizure:____

List any program restrictions we should be aware of:____

What medication and treatment plan is your child following? (If your child will take medication while in our care, a medication permission form must be completed.)____

____

If your child does not respond to medication and treatment what would you like the staff to do?__________

____

Can your child administer the medication and treatment themselves or does your child need help?________

If assistance is needed, what does the staff need to do? Please note; if staff need to help your child you will need to train them in specifics.____

____

Where is the medication stored?____

Is there any additional information staff must know in order to best serve your child?_________________

____

____

OFFICE USE ONLY

Received by:____ Date:_________________________

Copy to Site:__________________ Copy to Director:____________________ File:_________________________