INDIVIDUALIZED CARE PLAN (ICCP) – SEIZURE

Child's Name: ______________________________ Birth Date: ______________________

Health Care Provider Name: ______________________ Clinic: ______________________

Address: ____

Telephone Number(s): (______)______________________ (______)______________________

1. Diagnosed Medical Condition: ____
   a. When was your child first diagnosed? (Date) ______________ Is it a current health issue? Yes No
   b. If yes, describe how often it occurs: ____________________________________
      Are seizures related to something special? ______________________________
   c. What symptoms and behavior does your child experience?
      1) Before the seizure: ____
      2) During the seizure: ____
      3) After the seizure: ____
   d. List any restrictions at CDLC: ____
2. Treatment and Medication:
   a. Routine treatment(s) and medication(s): ______________________________
   b. As needed (PRN) treatment(s) and medication(s): ______________________
3. Emergency Care: If your child does not respond to medication and treatment, the emergency plan is:

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4. Child's Knowledge:
   a. What is your child's understanding of the medical condition? ____________________
   b. Does your child understand about any restrictions at CDLC? ____________________
   c. Can your child tell the teacher when treatment and medication is needed? Yes No
   d. Does your child cooperate with treatment and medication? Yes No
5. Additional Information and/or Health Care Provider's recommendations: ____________________

______________________________ ______________________________
Parent/Guardian Signature – Date Health Care Provider Signature – Date

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Teacher Signature – Date