



## 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:

\_\_\_\_\_

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

\_\_\_\_\_  
Teacher Signature - Date