Public Health
Seattle & King County

Seizure Care Plan WAC Compliance Checklist

To be completed by parent/guardian:

Child's Name: _____ **Date of Birth:** _____

1. My child has been diagnosed with a seizure condition by _____
   Name of Licensed Healthcare Provider
   with _____
   Name of clinic/medical practice

2. A copy of my child's Seizure Care Plan*, signed by a licensed health care professional, is attached to this form:
   - ☐ **Yes**
   - ☐ **No** (child care provider must have parent/guardian provide a signed Seizure Care Plan from child's licensed healthcare provider **before** child attends or resumes care)

3. My child has been prescribed an **emergency anti-seizure medication** (such as: Midazolam, Diastat, etc.)
   - ☐ **Yes** (see attached care plan)
   - ☐ **No**

4. My child takes **daily medication for seizure control**:
   - ☐ **Yes** (see attached care plan)
   - ☐ **No**

   If Yes, the child is **REQUIRED** to have:
   - ☐ A prescription for a 3-day supply of critical daily seizure control medication to be given at child care/early learning program in case of disaster requiring child to remain in care past usual hours.
   - ☐ 3-Day Critical Medication Form signed by Parent/Guardian

   My child's daily medication for seizure control is administered (check all that apply):
   - ☐ At home, during non-program hours
   - ☐ At child care/early learning program at the following time(s): _____

5. **Hospital Preference:** _____

6. **Seizure Care Plan is valid from: ___/___/___ (Start Date) until ___/___/___ (End Date).**
   End date is a maximum of one year from Licensed Healthcare Provider's signature on the child's Seizure Care Plan

***Disclaimer:** this form is intended to **supplement a Seizure Care Plan provided by a licensed healthcare provider, in order to comply with Washington Administrative Code (WAC) (**110-300-0215 and 110-300-0300) **requirements).** The checklists below indicate the items that **must** be included in the Individual Care plan, per WAC requirements. If any items are incomplete, child care/early learning program director must ask parent/guardian to request this information from the licensed healthcare provider prior to starting/continuing onsite care.*

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Emergency Contact Information *(parents/guardians & additional contact if available)*

Emergency Contact #1	Phone:
Name: _____ **Relation:** _____	**(____)_____**
Emergency Contact # 2	**Phone:**
Name: _____ **Relation:** _____	**(____)_____**
Emergency Contact # 3	**Phone:**
Name: _____ **Relation:** _____	**(____)_____**

Checklist for SEIZURE CARE PLAN:

Look at the Seizure Care Plan provided by licensed healthcare provider to make sure it includes the following items, per WAC (110-300-0300 and 110-300-0215) requirements:

- ☐ Diagnosis (medical need)
- ☐ Description of triggers that can cause seizure activity
- ☐ When to give emergency seizure medication (known symptoms of seizures)
- ☐ List of anti-seizure **emergency** medications, and seizure **control** medications, if prescribed
- ☐ Possible side effects of medication(s)
- ☐ Directions on how to administer medication(s)
- ☐ Parent/guardian **and** licensed healthcare provider signatures
- ☐ Contact information for the primary healthcare provider or other relevant specialist

Checklist for EMERGENCY SEIZURE MEDICATION: _____
Name of Medication

Medication must be listed on the Seizure Care Plan. Look at **prescription label** to make sure it includes the following items:

- ☐ Child's first/last name
- ☐ Date prescription was filled
- ☐ Name and contact information of the prescribing licensed health professional
- ☐ Expiration date
- ☐ Dosage amount
- ☐ Instructions for administration
- ☐ Storage requirements

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Checklist for DAILY SEIZURE CONTROL MEDICATIONS: _____

Name of Medication(s)

- *If NO daily seizure control medication is prescribed, skip to "Checklist to Meet Additional WAC Requirements."*
- *If more than one daily seizure control medication is taken, please complete this checklist for each medication.*

Medication must be listed on the Seizure Care Plan. Look at **prescription label** to make sure it includes the following items:

- ☐ Child's first/last name
- ☐ Date prescription was filled
- ☐ Name and contact info of the prescribing health professional
- ☐ Expiration date
- ☐ Dosage amount
- ☐ Instructions for administration
- ☐ Storage requirements

Checklist to Meet Additional WAC Requirements:

- ☐ Seizure Care Plan must be updated annually or sooner if the Seizure Care Plan has been revised by the licensed healthcare provider
- ☐ Early learning program staff has been trained by the child's parent/guardian/appointed designee on implementing special medical procedures that are required in the child's Seizure Care Plan
- ☐ Training has been documented and signed by the childcare/ early learning provider and the child's parent or guardian (or designee)

Staff Training Documentation:
Parent/guardian or appointed designee has provided training to the staff listed below about specialized medication administration procedures for their child specific to all medication(s) listed in the child's Seizure Care Plan, as written by their licensed healthcare provider.

_____ _____
Signature of parent/guardian Date

_____ _____
Signature of designee (if applicable) Date

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Staff Name (printed)	Trainer Name (parent/guardian or appointed designee)	Date of Training	Staff Signature

I hereby give permission for the staff of _____ to give my child
Name of childcare/early learning program

the medication(s) as prescribed in the Seizure Care Plan by their Licensed Healthcare Provider and as documented above.

_____ _____
Signature of parent/guardian Date

_____ _____
Signature of designee (if applicable) Date

_____ _____
Signature of child care/early learning Program Director Date

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3-DAY CRITICAL MEDICATION AUTHORIZATION FORM

(This medication is only to be used in case of disaster requiring the child to remain in care past usual hours)

Child's Name:	**Date of Birth/Age:**
Name of Medication:	**Reason for Medication:**
Expiration date of medication (date medication needs to be replaced): **____/____/____**	**Special Instructions:**
☐ **Scheduled times to be given (please list times below):**	☐ **To be given as needed for the following symptoms (please list symptoms below):**
Dose (Amount to be given):	
Possible Side Effects:	**Route:** ☐ **Oral** ☐ **Other _____**
☐ **Above information consistent with label?**	**Requires Refrigeration:** ☐ **Yes** ☐ **No**
This Medication Authorization Form is valid for a maximum of one year* from Licensed Healthcare Provider's signature on the child's Seizure Care Plan: **____/____/____** **(date to be renewed)** ***NOTE: This Medication Authorization Form must be replaced any time there are changes to this child's health condition or prescribed medications.**	

_____ _____

Parent/Guardian Signature **Date**

(_____)_____

Daytime Phone Number

SEE Seizure Care Plan_____

Health Care Provider Signature

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SEIZURE ACTIVITY LOG

Note: This should be accompanied by the child's Seizure Care Plan on-file for this child.

Name of Child: _____ Date of Birth: _____ Room: _____

DATE	TIME SEIZURE STARTED	TIME SEIZURE ENDED	CIRCUMSTANCES BEFORE SEIZURE BEGAN (activity child was participating in)	DESCRIBE SEIZURE*	ACTIONS TAKEN BY STAFF	MEDICATION GIVEN: YES or NO (If YES, indicate time given. If NO, reason not given)	CHILD'S BEHAVIOR AFTER SEIZURE	STAFF NAME (person making entry)

***What to look for and note above:**

1. Sudden Stare
2. Unresponsive to name
3. Picking or fumbling movements of hands
4. Prompt recovery (seconds)
5. Gradual recovery (minutes)
6. Slow recovery (confused/ needing sleep)
7. Clenched jaw or tongue bitten
8. Unconsciousness
9. Color change or breathing problem
10. Stiff and/or jerky movements
11. Lip smacking
12. Eye fluttering

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Medication Record

(Must be filled out by the person who gives the medication)

Child's Name:
Name of Medication:

Date	Time Given	Dosage	Initials	Side Effects Observed

Initials and signatures of persons giving medication:

_____ _____ _____ _____

_____ _____ _____ _____