Minnesota Visiting Nurse Agency
3433 Broadway Street NE, Suite 300
Minneapolis, MN 55413

Individualized Child 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 a specific condition?
   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 day care:
2. Treatment and Medication (Complete MEDICATION PERMISSION Form):
   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 day care?

   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 Signature/Date: Health Care Provider Signature/Date: